XVI CONGRESSO NACIONAL

SOCIEDADE PORTUGUESA DE ANDROLOGIA, MEDICINA SEXUAL E REPRODUÇÃO

XIII REUNIÃO IBÉRICA DE ANDROLOGIA, MEDICINA SEXUAL E REPRODUÇÃO

ESAU Oporto Meeting
EAU Section of Andrological Urology

Ipanema Park Hotel – Porto
31 maio a 03 junho de 2018

PROGRAMA CIENTÍFICO

Consultar versão digital do Programa


DOW'S

XVI CONGRESSO NACIONAL SPA

SOCIEDADE PORTUGUESA DE ANDROLOGIA, MEDICINA SEXUAL E REPRODUÇÃO

XIII REUNIÃO IBÉRICA DE ANDROLOGIA, MEDICINA SEXUAL E REPRODUÇÃO

ESAU Oporto Meeting
EAU Section of Andrological Urology

Presidente do Congresso / Presidente da SPA

Pedro Vendeira

Comissão Organizadora

António Campos | Artur Palmas | Bruno Graça | Bruno Pereira | Lisa Vicente | Manuel Vila Mendes | Pepe Cardoso

Comissão Científica

Carla Costa | La Fuente de Carvalho | Luís Ferraz | Nuno Louro | Nuno Tomada | Pedro Eufrásio | Sandra Vilarinho

Comissão Científica para a Selecção de Comunicações Livres

Bruno Pereira | Nuno Tomada | Pedro Vendeira

Júri de Comunicações Livres

Júri de Comunicações Orais 1

Alfredo Soares | Fortunato Barros

Júri de *Posters*

Ferdinando Pereira | Jorge Morales | José Dias | Pedro Vendeira

Júri de Comunicações Orais 2 e Vídeos

António Campos | Francisco Martins

SPA

SOCIEDADE PORTUGUESA
DE ANDROLOGIA, MEDICINA SEXUAL E REPRODUÇÃO

Intervenientes no Programa

Nacionais

Alberto Barros | Alberto Silva | Alfredo Soares | António Campos | Artur Palmas | Bruno Graça | Bruno Pereira | Carla Costa | Carla Veiga Rodrigues | Ferdinando Pereira | Filipa Vilaça | Fortunato Barros | Francisco Martins | Francisco Rolo | Frederico Reis | Graça Santos | Hélder Dores | Helena Marques | Joana Menezes | Joana Mesquita Guimarães | Joana Saraiva | Joana Silva | João Silva | Joaquim Lindoro | Jorge Morales | Jorge Silva | José Dias | La Fuente de Carvalho | Lilian Campos | Lisa Vicente | Luís Costa | Luís Ferraz | Luís Sousa | Marta Osório | M. Vila Mendes | Márcia Mota | Nuno Azevedo | Nuno Domingues | Nuno Louro | Nuno Monteiro Pereira | Nuno Tomada | Paulo Temido | Pedro Baptista | Pedro Eufrásio | Pedro Nobre | Pedro Oliveira | Pedro Vendeira | Pepe Cardoso | Renato Martins | Ricardo Ramires | Rocha Mendes | Sandra Vilarinho | Sérgio Santos | Sofia Santos Lopes | Susana Renca | Vanda Patrício | Vânia Beliz | Vítor Oliveira

Internacionais

Aleksander Giwercman (SE) | Ana Puigvert (SP) | Andrea Salonia (IT) | Asif Muneer (UK) | Ates Kadioglu (TK) | Baris Altay (TK) | Carlo Bettocchi (IT) | Eduard Ruiz Castañé (SP) | Enzo Palminteri (IT) | Ferdinando Fusco (IT) | Fernando Meijide (SP) | Ferrán García (SP) | Fotios Dimitriadis (GR) | Juan Álvarez (SP) | Maarten Albersen (BE) | Miroslav Djordjevic (RS) | Muammer Kendirci (TK) | Mustafa Usta (TK) | Natalio Cruz (SP) | Nikolaos Sofikitis (GR) | Oleg Apolikhin (RU) | Onder Yaman (TK) | Paulo Egydio (BR) | Rafael Prieto (SP) | Run Wang (US) | Selahittin Çayan (TK) | Suks Minhas (UK) | Thorsten Diemer (DE) | Zsolt Kopa (HU)

Mensagem do Presidente

Caros Colegas

A Sociedade Portuguesa de Andrologia, Medicina Sexual e Reprodução (SPA) está a celebrar o seu XVI Congresso Nacional, pugnando uma vez mais pela formação específica, profissional e competente dos profissionais de saúde ligados a esta temática, bem como pela divulgação da ciência relevante, recentemente produzida, no âmbito desta área médica.

Todos os anos (alternando entre Portugal e Espanha), tem lugar a Reunião Ibérica de Andrologia, Medicina Sexual e Reprodução. Em 2018, para além de acolher o Congresso da SPA, a invicta cidade do Porto irá acolher o XIII Encontro Ibérico, com a certeza de que tão estimada confraternização se tornará um espaço de troca de conhecimentos e, sobretudo, de experiências entre pares.

Localizado ao longo do estuário do rio Douro, no norte de Portugal, o Porto é um dos centros europeus mais antigos e acolhido como Património Mundial pela UNESCO em 1996. O seu registo remonta a muitos séculos, quando era um posto avançado do Império Romano. Agora, é hora de se tornar um posto avançado das Futuras Gerações da Andrologia, Medicina Sexual e Reprodução.

A grande novidade para 2018 será a estreia em Portugal de uma reunião *ESAU* em simultâneo com a nossa Reunião Magna. A *ESAU Oporto Meeting*, que terá lugar no dia 2 de Junho, vai promover a presença do *Board* Europeu de Andrologia Urológica (*European Section of Andrological Urology – European Association of Urology*). Fruto das boas relações entre a SPA e os seus congéneres Europeus, temos assim a grande oportunidade de poder aprender e discutir sobre os temas mais polémicos da actualidade, com a presença dos mais reputados especialistas mundiais na área de Andrologia, Medicina Sexual e Reprodução.

Acreditem, vai valer a pena!

Pedro Vendeira
Presidente
Sociedade Portuguesa de Andrologia, Medicina Sexual e Reprodução

Program at a glance

31 maio	01 junho	02 junho	03 junho
WORKSHOP 1 (Pág. 07)	**REUNIÃO IBÉRICA** (Pág. 10)	***ESAU MEETING*** (Pág. 15)	**CONGRESSO NACIONAL SPA** (Pág. 13)
WORKSHOP 2 (Pág. 07)			
WORKSHOP 3 (Pág. 07)	**CONGRESSO NACIONAL SPA** (Pág. 11)		
WORKSHOP 4 (Pág. 07)			
CONGRESSO NACIONAL SPA (Pág. 08)		JANTAR DO CONGRESSO	

Quinta-feira / 31 de maio de 2018

WORKSHOPS PRÉ-CONGRESSO

08:00h — Abertura do Secretariado

09:00-10:30h — **WORKSHOP 1**

INFERTILIDADE CONJUGAL EM MGF
Docentes: Helena Marques, Luís Ferraz e Marta Osório

10:30-12:00h — **WORKSHOP 2**

DISFUNÇÃO SEXUAL FEMININA E ESTÉTICA VULVO-VAGINAL
Docentes: Márcia Mota, Joana Silva e Pedro Baptista

12:00-13:30h — **WORKSHOP 3**

***UPDATE* EM CIRURGIA PENIANA: DA PRÓTESE À COSMÉTICA**
Docentes: Paulo Egydio (BR), Nuno Tomada e Natalio Cruz (SP)

13:30-15:00h — **WORKSHOP 4**

EJACULAÇÃO PREMATURA – *STEP BY STEP*
Docentes: Bruno Pereira, Sandra Vilarinho e Carla Veiga Rodrigues

Definição e epidemiologia da ejaculação prematura: Carla Veiga

Etiologia e classificação da ejaculação prematura: Bruno Pereira

Avaliação do doente com ejaculação prematura (*Steps* 1 e 2): Carla Veiga

Envolvimento do casal, discussão/partilha de decisões e planeamento do tratamento (*Step* 3): Sandra Vilarinho

Abordagem cognitiva e comportamental e terapia sexual (*Step* 4, parte 1): Sandra Vilarinho

Mudança do estilo de vida, terapêuticas tópicas, farmacológicas e minimamente invasivas (*Step* 4, parte 2): Bruno Jorge Pereira

Avaliação do bem-estar sexual (*Step* 5): Sandra Vilarinho

Benefícios da actividade sexual: Carla Veiga

Casos clínicos

Discussão

15:00-15:30h *Coffee-Break*

XVI CONGRESSO NACIONAL DA SOCIEDADE PORTUGUESA DE ANDROLOGIA, MEDICINA SEXUAL E REPRODUÇÃO

15:30-16:00h **CONFERÊNCIA INAUGURAL**

Diversidade e disforia de género em 2018
Presidente: Nuno Monteiro Pereira
Palestrante: Graça Santos

16:00-16:30h **SESSÃO DE ABERTURA**

Dr. Manuel Pizarro, *Vereador da Câmara Municipal do Porto*
Dr. Miguel Guimarães, *Bastonário da Ordem dos Médicos*
Prof. Doutor Nuno Monteiro Pereira, *Coordenador do Colégio da Competência em Sexologia Clínica da Ordem dos Médicos*
Prof. Doutor Pedro Vendeira, *Presidente da Sociedade Portuguesa de Andrologia, Medicina Sexual e Reprodução (SPA)*
Prof. Doutora Sandra Vilarinho, *Presidente da Sociedade Portuguesa de Sexologia Clínica (SPSC)*
Dr. Luís Abranches Monteiro, *Presidente da Associação Portuguesa de Urologia (APU)*

16:30-17:30h **MESA-REDONDA: ENDOCRINOLOGIA SEXUAL**

Moderadores: Rocha Mendes e Paulo Temido
Diagnóstico e tratamento da hiperprolactinémia no homem *(15')*
Joana Menezes
Disfunções tiroideias e sexualidade *(15')*
Joana Saraiva
Como compensar o uso recreativo de esteróides anabolizantes *(15')*
João Silva
Discussão *(15')*

17:30-18:15h **SESSÃO TEMÁTICA: ONCOSSEXUALIDADE**

Moderadores: Frederico Reis e Lisa Vicente
No masculino *(15')*
Jorge Silva
No feminino *(15')*
Vanda Patrício
Discussão *(15')*

18:15-19:15h **MESA-REDONDA: *SPOTS* POLÉMICOS EM SEXUALIDADE**

SOCIEDADE PORTUGUESA DE SEXOLOGIA CLÍNICA (SPSC) E SOCIEDADE PORTUGUESA DE ANDROLOGIA, MEDICINA SEXUAL E REPRODUÇÃO (SPA)

Moderadores: Sandra Vilarinho e Nuno Tomada

Tecnologia, redes sociais e sexualidade – *To Google or not to Google* *(15')*
Nuno Azevedo

Pornografia e disfunção sexual: Nociva ou aliada? *(15')*
Vânia Beliz

Disfunção eréctil psicogénica – Farmacoterapia oral é a solução? *(15')*
Pedro Nobre

Discussão *(15')*

19:15h Encerramento dos trabalhos do primeiro dia

19:45h **PORTO DE HONRA**

Lançamento do livro "**Peniopatia Diabética**" da autoria de La Fuente de Carvalho, Nuno Louro e Javier Angulo Frutos

Sexta-feira / 01 de junho de 2018

XIII REUNIÃO IBÉRICA DE ANDROLOGIA, MEDICINA SEXUAL E REPRODUÇÃO

07:30h	Abertura do Secretariado
08:30-08:40h	**SESSÃO DE ABERTURA**
	Pedro Vendeira (PT) e Ferrán García (SP)
08:40-10:00h	**MESA-REDONDA INTERACTIVA: DISFUNÇÕES SEXUAIS**
	Moderadores: Pedro Vendeira (PT) e Rafael Prieto (SP) **Disfunções sexuais masculinas – Terapêuticas combinadas** *(20')* Artur Palmas (PT) **Disfunções sexuais femininas – Terapêuticas combinadas** *(20')* Ana Puigvert (SP) **Casos clínicos e discussão** *(40')* Fernando Meijide (SP) e La Fuente de Carvalho (PT)
10:00-10:30h	**CONFERÊNCIA – *QUO VADIS*, ANDROLOGIA**
	Presidente: Rafael Prieto (SP) Palestrante: Nuno Monteiro Pereira (PT)
10:30-10:45h	*Coffee-Break*
10.45-11.45h	**MESA-REDONDA INTERACTIVA: SEXUALIDADE E INFERTILIDADE / INFERTILIDADE E SEXUALIDADE. O VERDADEIRO IMPACTO?**
	Moderadores: Pepe Cardoso (PT) e Ferrán García (SP) Palestrantes: Lilian Campos (PT) e Vítor Oliveira (PT) **Discussão pública**
11:45-11:50h	**SESSÃO DE ENCERRAMENTO**
	Pedro Vendeira (PT) e Ferrán García (SP)

12:00-13:00h **SIMPÓSIO** JABA RECORDATI GROUP

13:00-14:30h Almoço

14:30-15:30h **SESSÃO DE COMUNICAÇÕES ORAIS 1** – CO 01 a CO 09 (Pág. 50)

Júri: Fortunato Barros e Alfredo Soares

15:30-17:00h **MESA-REDONDA: INFERTILIDADE**

Moderadores: Luís Ferraz e Alberto Barros
Enquadramento legal actual da procriação medicamente assistida *(20)*
Joana Mesquita Guimarães
***Update* do impacto das drogas na fertilidade** *(20)*
Nuno Louro
Extração de gâmetas: Há consequências sexuais e globais na saúde?
- No Masculino *(15)*
Luís Sousa
- No Feminino *(15)*
Renato Martins
Discussão *(20)*

17:00-17:30h *Coffee-break* e visita aos *Posters*

Júri: Pedro Vendeira e Ferdinando Pereira

17:30-18:30h **MESA-REDONDA: NEUROFARMACOLOGIA SEXUAL**

Moderadores: Márcia Mota e Artur Palmas
Novos ISRS's – Desprovidos de efeitos secundários sexuais? *(15)*
Susana Renca
Dispareunia masculina e disfunção ejaculatória *(15)*
Sofia Santos Lopes
Alterações do orgasmo masculino – Há medicação eficaz? *(15)*
Bruno Graça e Alberto Silva
Discussão *(15)*

18:30-19:00h **CONFERÊNCIA MAGISTRAL**

Infertility is the mirror of general health…
Chair: Pedro Eufrásio
Speaker: Asif Muneer (UK)

19:00-19:30h **MESA-REDONDA: *SPOTS* POLÉMICOS EM ANDROLOGIA, MEDICINA SEXUAL E REPRODUÇÃO**

Moderadores: Francisco Rolo e Sérgio Santos

***Update* em microlitíase testicular: Implicações andrológicas e reprodutivas** *(15)*
Pedro Eufrásio

Disfunção eréctil/Ejaculação prematura/La Peyronie: Tratamentos emergentes *(15)*
Bruno Pereira

19:30h Encerramento dos trabalhos do segundo dia

Sábado / 02 de junho de 2018

07:30h Abertura do Secretariado

08:30-18:45h ***ESAU OPORTO MEETING***

JOINT MEETING ESAU – PORTUGUESE SOCIETY OF ANDROLOGY, SEXUAL MEDICINE AND REPRODUCTION
ANDROLOGY IN EUROPE 2018

Consulte o programa na página 15 / *See the program on page 15*

XVI CONGRESSO NACIONAL DA SOCIEDADE PORTUGUESA DE ANDROLOGIA, MEDICINA SEXUAL E REPRODUÇÃO

20:30h **JANTAR DO CONGRESSO**

ENTREGA DO PRÉMIO ALEXANDRE MOREIRA 2016/2017

Domingo / 03 de junho de 2018

08:00h	Abertura do Secretariado
08:30-09:30h	**SESSÃO DE COMUNICAÇÕES ORAIS 2** – CO 10 a CO 14 (Pág. 56) **E VÍDEOS** – V 01 a V 09 (Pág. 59)
	Júri: António Campos e Francisco Martins
09:30-11:00h	***JOINT SYMPOSIUM: ESSM GOES NATIONAL***
	EUROPEAN SOCIETY FOR SEXUAL MEDICINE (ESSM) AND SOCIEDADE PORTUGUESA DE ANDROLOGIA, MEDICINA SEXUAL E REPRODUÇÃO (SPA) Chairs: Pedro Vendeira and Carla Costa ***Severe ED in neurogenic patients. Is there a best penile implant?*** *(20)* Alberto Silva ***Penile lengthening and widening in prosthetic surgery. Tips and tricks*** *(20)* Carlo Bettocchi (IT) ***Low-intensity extracorporeal shock wave treatment improves erectile function: Reality or fantasy?*** *(20)* Maarten Albersen (BE) ***ESSM educational activities. Where are we going?*** *(15)* Carla Costa ***Discussion*** *(15')*
11:00-11:40h	**WORKSHOP: COMO EU FAÇO (EM 10 MINUTOS) –** ***TIPS AND TRICKS***
	Moderadores: Joaquim Lindoro e Ricardo Ramires **TESE/TESA – Técnicas** *(10')* Pedro Oliveira **Ultrassonografia doppler peniana/escrotal** *(10')* Nuno Tomada **Interpretar um espermograma** *(10')* Luís Costa **Ondas de choque de baixa intensidade na DE: Ao meu modo** *(10')* Nuno Domingues
11:40-12:15h	Coffee-break e visita aos *Posters*
	Júri: José Dias e Jorge Morales

12:15-13:30h **MESA-REDONDA: SEXUALIDADE E CUIDADOS PRIMÁRIOS**

SOCIEDADE PORTUGUESA DE ANDROLOGIA, MEDICINA SEXUAL E REPRODUÇÃO (SPA) E GRUPO DE ESTUDOS DA SEXUALIDADE (GESEX) DA ASSOCIAÇÃO PORTUGUESA DE MEDICINA GERAL E FAMILIAR (APMGF)

Moderadores: M. Vila Mendes e Carla Veiga Rodrigues

"Quando o amor dói" – Pavimento pélvico hiperactivo: Erecção dolorosa e vulvodínia *(20)*
Filipa Vilaça

Como avaliar o risco cardiovascular em 2018: Quanto vale a disfunção eréctil? *(20)*
Hélder Dores

Disfunções sexuais femininas – Pontos a reter no âmbito da MGF *(20)*
Lisa Vicente

Discussão *(15)*

13:30-14:15h **CONSENSO HPV – DISCUSSÃO PRELIMINAR**

Artur Palmas, Bruno Graça, Bruno Pereira e Pedro Eufrásio

14:15-14:30h Sessão de Encerramento e Entrega de Prémios

esau

SPA
SOCIEDADE PORTUGUESA
DE ANDROLOGIA, MEDICINA SEXUAL E REPRODUÇÃO

ESAU Oporto Meeting

Joint Meeting ESAU - Portuguese Society of Andrology

Ipanema Park Hotel – Oporto

June 2, 2018

ANDROLOGY IN EUROPE 2018

Dear Colleagues,

The Members of The Board of The European Section of Andrological Urology (ESAU) of The European Association of Urology would like to welcome you in Oporto on June 2nd 2018 in The Joint Scientific Meeting of ESAU together with The Portuguese Society of Andrology.

Andrology brings males closer to females raising their reproductive and sexual function pathophysiology. In fact Andrology starts with the desire of a male and female to approach each other and ends in the coalescence of the male gamete with the female gamete with the subsequent generation of the human life.

Let us meet in the beautiful town of Oporto to discuss extensively most of the dysfunction impeding physical or gamete contact, drink a glass of Oporto wine, and listen to some great Latin music.

On behalf of The ESAU Board,

Nikolaos Sofikitis, MD, PhD, DMSci
Professor of Urology and ESAU Chair

Dear Colleagues and Friends,

"The game is afoot".

It is with a great joy, satisfaction, proud and honor, that The Portuguese Society of Andrology, Sexual Medicine and Reproduction welcomes the ESAU Oporto Meeting for the first time in history.

This important event that will be held together with our biannual National Meeting, will take place on June 2, 2018 in Oporto, Portugal, and it will be remembered as a great success because of three main reasons: science, education and friendship.

We will have the opportunity to attend high quality scientific sessions, and to be updated about all the new technologies and treatments that will assist all of us in our daily practice in this beautiful field.

Located along the Douro River estuary in northern Portugal, Oporto is one of the oldest European centres, and registered as a World Heritage Site by UNESCO in 1996. Its settlement dates back many centuries, when it was an outpost of the Roman Empire. Now, it is the time to become an outpost of the Andrology Future Generations.

In the words of many visitors, this city has something mystical that is difficult to describe and which varies according to the place, time of day and light.

One of Portugal's internationally famous exports, Port Wine, is named for Oporto, since the metropolitan area, and in particular, the adegas of Vila Nova de Gaia were responsible for the production and export of this fortified wine. A must for the senses… don't miss it!

We encourage you to join us in Oporto in order to enjoy a mixture of science and culture, in the warm company of friends and colleagues.

Pedro Vendeira
President
The Portuguese Society of Andrology, Sexual Medicine and Reproduction

ESAU BOARD

N. Sofikitis
Ioannina (GR)
Chairman

M. Dinkelman
Rotterdam (NL)
Member

T. Diemer
Gießen (DE)
Member

S. Minhas
London (UK)
Member

F. Fusco
Naples (IT)
Member

A. Giwercman
Malmö (SE)
Member

A. Kadioglu
Istanbul (TK)
Member

A. Salonia
Milan (IT)
Member

Z. Kopa
Budapest (HU)
Member

P. Verze
Naples (IT)
Ex-Officio

AWARD COMMITTEE

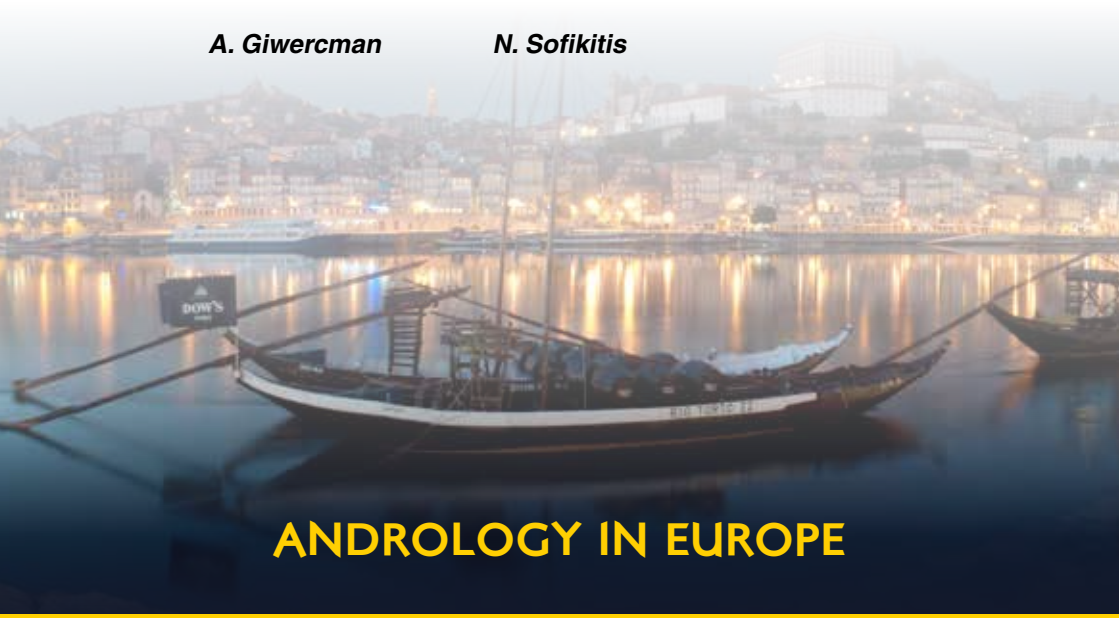
E. Ruiz Castané

A. Kadioglu

P. Vendeira

A. Giwercman

N. Sofikitis



ANDROLOGY IN EUROPE

Saturday / June 02, 2018

ESAU – *Portuguese Society of Andrology, Sexual Medicine and Reproduction*
***Joint Meeting: ANDROLOGY IN EUROPE* 2018**

07:30am	*Opening of registration desk*
08:30am-08:40am	***WELCOME AND INTRODUCTION***
	Pedro Vendeira (PT) and Nikolaos Sofikitis (GR)
08:40am-09:00am	***STATE OF THE ART LECTURE I***
	Moderator: Asif Muneer (UK)
	Endocrine disruption and infertility: Is the winter coming?
	Speaker: Suks Minhas (UK)
09:00am-10:00am	***MALE INFERTILITY: TREATMENT CONTROVERSIES***
	Moderators: Zsolt Kopa (HU) and Carlo Bettocchi (IT)
09:00am-09:15am	***PDE5 inhibitors as an adjunct tool for the therapeutic management of male infertility***
	Speaker: Nikolaos Sofikitis (GR)
09:15am-09:30am	***Predictive factors of successful treatment for testicular dysfunction in patients with hypogonadotropic hypogonadism***
	Speaker: Thorsten Diemer (DE)
09:30am-09:45am	***Recurrent varicoceles: diagnosis and treatment***
	Speaker: Selahittin Çayan (TK)
09:45am-10:00am	***Is there a role for robotic surgery in the alleviation of male infertility today?***
	Speaker: Pedro Vendeira (PT)
10:00am-10:40am	***DEBATES IN ANDROLOGY***
	Moderators: Pepe Cardoso (PT) and Carlo Bettocchi (IT)
10:00am-10:20am	***Debate 1: Does every boy with adolescent varicocele require surgical treatment?***
	Supporting the hypothesis
	Speaker: Luís Sousa (PT)
	Rejecting the hypothesis
	Speaker: Ferdinando Fusco (IT)

10:20am-10:40am	***Debate 2: Is penile rehabilitation following radical prostatectomy evidence based?*** ***Supporting the hypothesis*** *Speaker:* Run Wang (US) ***Rejecting the hypothesis*** *Speaker:* Ates Kadioglu (TK)
10:40am-11:00am	*Coffee-Break*
11:00am-12:00am	***PENILE AND URETHRAL SURGERY TODAY***
	Moderators: Mustafa Usta (TK) and Pedro Vendeira (PT)
11:00am-11:15am	***Tips and tricks in Peyronie's IPP Surgery*** *Speaker:* Paulo Egydio (BR)
11:15am-11:30am	***Penile implants: Preventing infections in 2018*** *Speaker:* Carlo Bettocchi (IT)
11:30am-11:45am	***Staging and treatment steps in panurethral strictures*** *Speaker:* Enzo Palminteri (IT)
11:45am-12:00am	***Reconstructing the urethra: Best options on flaps and/or grafts*** *Speaker:* Miroslav Djordjevic (RS)
12:00am-01.00pm	***SPERM RETRIEVAL IN SPECIFIC SITUATIONS***
	Moderators: Suks Minhas (UK) and Pedro Eufrásio (PT)
12:00am-12:15am	***Retrieval, processing and selection of sperm for ICSI: What should an urologist know?*** *Speaker:* Fotios Dimitriadis (GR)
12:15am-12:30am	***Sperm retrieval in patients with HIV, hepatitis B and C, HTLV: What is new?*** *Speaker:* Nuno Louro (PT)
12:30am-12:45am	***Sperm retrieval from men with spinal cord injury*** *Speaker:* Carlo Bettocchi (IT)
12:45am-01:00pm	***Sperm recovery from men with chromosomal abnormalities or Y-chromosome microdeletions*** *Speaker:* Zsolt Kopa (HU)
01.00pm-02:30pm	*Lunch Break*

02:30pm-03:45pm	***HOT-SPOTS IN ANDROLOGY***
	Moderators: Run Wang (US) and Nikolaos Sofikitis (GR)
02:30pm-02:45pm	"***Oral" STD's: The new paradigms in sexual behaviors***
	Speaker: Asif Muneer (UK)
02:45pm-03:00pm	***LI-ESWT as a treatment for erectile dysfunction after bilateral nerve-sparing radical prostatectomy***
	Speaker: Muammer Kendirci (TK)
03:00pm-03:15pm	***Hematospermia: Current evaluation and treatment modalities***
	Speaker: Oleg Apolikhin (RU)
03:15pm-03:30pm	***Which is the male's target to induce a female orgasm: The clitoris or the vagina?***
	Speaker: Sandra Vilarinho (PT)
03:30pm-03:45pm	***Current and Emerging Treatments for Premature Ejaculation***
	Speaker: Mustafa Usta (TK)
03:45pm-04:45pm	***SEX IN MEN WITH PROSTATIC CANCER***
	Moderators: Nuno Tomada and Onder Yaman (TK)
03:45pm-04:00pm	***Prostate cancer, androgen deprivation and sex: To do or not to do?***
	Speaker: Andrea Salonia (IT)
04:00pm-04:15pm	***Erectile dysfunction and orgasmic dysfunction post-radical prostatectomy: Comparison of robotic assisted procedures versus open surgery***
	Speaker: Ferdinando Fusco (IT)
04:15pm-04:30pm	***Testosterone replacement therapy in hypogonadal men with localized prostate cancer and/or post-radical prostatectomy: Are we ready?***
	Speaker: Suks Minhas (UK)
04:30pm-04:45pm	***Penile rehabilitation after radical prostatectomy: When do we start?***
	Speaker: Eduard Ruiz Castañé (SP)
04:45pm-05:15pm	*Coffee-Break*

05:15pm-06:15pm	***THE ANDROLOGY INFERTILITY LABORATORY: WHAT SHOULD THE CLINICIAN KNOW?***
	Moderators: Oleg Apolikhin (RU) and Vítor Oliveira (PT)
05:15pm-05:30pm	***Limitations of the standard parameters of semen analysis to predict the sperm fertilizing potential*** *Speaker:* Aleksander Giwercman (SE)
05:30pm-05:45pm	***Biochemistry of the seminal plasma and diagnosis of obstructive azoospermia*** *Speaker:* Bruno Pereira (PT)
05:45pm-06:00pm	***The clinical importance of assessing the presence of leukocytes in the semen*** *Speaker:* Baris Altay (TK)
06:00pm-06:15pm	***Reactive oxygen species, sperm DNA fragmentation assay, and administration of antioxidants: Is there an evidence based medicine?*** *Speaker:* Juan Álvarez (SP)
06:15pm-06:35pm	***STATE OF THE ART LECTURE II***
	Moderator: Eduard Ruiz Castañé (SP) ***Are there any pharmaceutical agents available for the alleviation of female sexual dysfunction?*** *Speaker:* Márcia Mota (PT)
06:35pm-06:45pm	***CLOSING REMARKS***
	Pedro Vendeira (PT) and Nikolaos Sofikitis (GR)

Exposição de Arte Fálica

O CULTO DO FALO: A PROPÓSITO DE UMA PEQUENA COLEÇÃO PESSOAL

Nuno Monteiro Pereira
Presidente da Sociedade Portuguesa de Andrologia em 2003/04 e 2005/06

Falo é o nome que se dá à representação do pénis. Na sociedade moderna, cada vez mais globalizada e uniforme, qualquer falo parece obsceno e indecente. Na antiguidade não o era. Pelo contrário, era considerado uma imagem sagrada, venerada como objecto de culto. Era considerada um símbolo místico e religioso, representava a força da primavera e a fecundidade da terra, protegia a vida contra as forças malignas que pudessem ameaçá-la.

O culto do falo estendeu-se por todo o globo, com maior ou menor expressão nalguns locais. Vigorou no Egipto, na Pérsia, na Síria, na Grécia, em Roma. Floresceu na Índia e no Japão. Estabeleceu-se em África. Quando os europeus chegaram às Américas, descobriram-no na cultura maia e azteca. Um culto tão antigo e tão espalhado universalmente não pode deixar de nos espantar e questionar.

Foi no período pré-histórico que surgiram as primeiras representações fálicas. Os menires, monumentos telúricos de evidente simbolismo místico e religioso, são velhas representações de masculinidade.

No Antigo Egipto, com a expansão da idolatria e do culto dos mortos, o falo passou a apresentar-se desproporcionadamente grande, revelando-se como verdadeiro objeto da veneração.

Na mitologia grega, a representação monumental de pénis eretos, à entrada de edifícios públicos, nomeadamente templos e teatros, é bem reveladora da importância simbólica que era atribuída ao pénis e à masculinidade.

Também a civilização romana foi rica em obras com um conteúdo fortemente erótico, encontradas em prostíbulos, mas também em casas particulares. Eram frequentes as imagens de Mercúrio, muitas vezes em bronze, sempre exibindo grandes falos. Ou os falos-amuletos, usados suspensos nos pescoços e nos ombros de homens, mulheres ou crianças, destinados a desviar efeitos de olhares invejosos.

Após a queda do Império Romano, com a crescente influência do cristianismo, o culto do falo foi diminuindo. A partir do século IV, os "pais da Igreja", particularmente Santo Agostinho, reinventaram o pudor e o pecado. A doutrina bíblica ensinava que Adão e Eva, quando expulsos do Paraíso, haviam sentido vergonha da sua nudez e coberto a região púbica com folhas de árvore. A representação do pénis foi, pois, remetida para uma ação proibida.

Com o Renascimento, a representação do pénis reapareceu na pintura e na escultura. O falo, antes associado ao divino, passou a estar associado ao masculino. Mas a Igreja em muitos casos mandou tapar a representação do órgão, à revelia dos desejos ou da memória dos seus autores.

No século XVIII, ressurgiu a arte erótica, acompanhando uma igual tendência na literatura. O pénis passou a ser mostrado como a masculinidade dominadora, adorado pelas mulheres e venerado pelos homens. O culto do falo reacendeu-se. Mas só no século XX, as provocações transgressoras das vanguardas artísticas consumaram a rotura. O pénis passou a ser representado com uma fortíssima carga erótica, por vezes agressiva, chocante, raiando o pornográfico. Mau grado variadas contracorrentes, o pénis continua, talvez até mais do que nunca, a simbolizar a condição masculina e a masculinidade.


DOW'S

LIMITATIONS OF THE STANDARD PARAMETERS OF SEMEN ANALYSIS TO PREDICT THE SPERM FERTILIZING POTENTIAL

Aleksander Giwercman
Dept. of Translational Medicine, Lund University, Malmö, Sweden

Standard semen parameters (SSP) include seminal volume, sperm concentration/total count, motility and morphology. SSP are used as proxy of male fertility in epidemiological and clinical studies, but also as a tool in clinical diagnosis of disturbances in male reproductive system as well as prediction of chance of pregnancy, in vivo and in vitro.

Although an association between SSP and chance of pregnancy in vivo has been found, their predictive value is rather poor. It has been reported that optimal chance of fertility is not achieved before the sperm concentration reaches the level of 40-50 x 106/mL, which is far above the lower level of normal range as defined by World Health Organization (WHO). Furthermore, even very low levels of sperm number, motility and morphology exclude the chance of spontaneous pregnancy and there is a considerable overlap between the "fertile" and "infertile" range of SSP. The predictive power of SSP in the context of in vitro fertilization is even poorer and by use of Intracytoplasmatic Sperm Injection pregnancy can be achieved in cases of azoospermia.

Therefore, there is a need of defining new sperm parameters which are superior to SSP in estimating chance of pregnancy in vivo and in vitro.

During the last few years a lot of attention has been given to methods for assessing sperm DNA integrity. DNA Fragmentation Index (DFI) can be measured by use of different methods, those which so far have proven to be most clinically useful being COMET and Sperm Chromatin Structure Assay. Although the role of these assays in clinical routine is still debated, there is a growing evidence that high DFI is associated with low chance of pregnancy in vivo and in vitro as well as higher risk of miscarriage. Although DFI analysis may become a new powerful tool in assessment of male fertility, the fact that infertility is related to the reproductive potential of both the male and the female partner implies a serious limitation for any method taking into consideration reproductive parameters of one of them only.

BIOCHEMISTRY OF THE SEMINAL PLASMA AND DIAGNOSIS OF OBSTRUCTIVE AZOOSPERMIA

Bruno Jorge Pereira, MD, FEBU, FECSM, Urology Specialist
Urology Department and Reproductive Medicine Unit of the Centro Centro Hospitalar da Cova da Beira, Covilhã, Portugal; Assistant Professor of Faculdade de Ciências da Saúde, Universidade da Beira Interior, Covilhã, Portugal. General Secretary of the Portuguese Society of Andrology, Sexual Medicine and Reproduction

Azoospermia occurs in about 1% of all men and 15% of infertile patients. In a systematized way it can be divided in pre-testicular azoospermia, testicular failure of non-obstructive Azoospermia (NOA),

obstructive azoospermia (OA) and post-testicular azoospermia. Pre-testicular azoospermia affects approximately 2% of men with azoospermia, and is generally due to a hypothalamic or pituitary abnormality diagnosed with hypogonadotropic hypogonadism. NOA is estimated to affect from 49% to 93% of all azoospermic men. While the term testicular failure would seem to indicate a complete absence of spermatogenesis, men with testicular failure may have either reduced spermatogenesis, maturation arrest at an early or late stage or a complete failure of spermatogenesis (Sertoli cell-only syndrome). Post-testicular obstruction or retrograde ejaculation are estimated to affect from 7% to 51% of all azoospermic patients (less common than NOA). In these cases, spermatogenesis is normal even though the semen lacks spermatozoa. Nonetheless, in clinical practice both components are sometimes present in a single patient (mixed genesis azoospermia).

OA classification depends on the location of the obstruction: intra-testicular obstruction, epididymal obstruction (most frequent – 30-67%), Vas deferens obstruction, cystic or post-inflammatory ejaculatory duct obstruction (rare – 1-3%) and functional obstruction of the distal seminal ducts.

The presentation intends to give some insights on how to diagnose a patient with OA based on clinical and diagnostic exams with special emphasis on current clinical biochemical markers and those under investigation.

The minimum initial evaluation of an azoospermic patient should include a complete medical history, physical examination, and hormonal levels measurement. The medical history should focus on prior fertility (primary or secondary infertility?), childhood illnesses such as cryptorchidism and mumps orchitis, genital trauma or pelvic/inguinal/scrotal surgeries, previous radiotherapy or chemotherapy and current medication. Previous bilateral cryptorchidism is frequently associated with gonadal dysfunction and the age of surgical correction and subsequent testicular development affects the spermatogenic prognosis. Inguinal hernioplasty and hydrocele interventions and orchidopexy itself may damage the seminal pathways and create a iatrogenic obstruction. Urological signs and symptoms such as hemospermia, burning micturition, reduced flow, urinary frequency and previous bladder catheterization should raise the suspicion that the proximal or distal seminal tract may be obstructed.

Chronic obstructive pulmonary diseases may be associated with OA in the case of primary ciliary dyskinesia (Kartagener Syndrome) or cystic fibrosis which may determine epididymal, vas deferens and seminal vesicles agenesis. The most common cause of congenital bilateral absence of the vas deferens (CBAVD) is the mutation of the cystic fibrosis CFTR gene. Family history of infertility or other genetic disorders is also of importance. Observation should include the evaluation of male secondary sexual characteristics, pelvic, inguinal and genital scars. Penile deformities should be excluded and testicles evaluated in relation to their size, shape and contours, consistency and symmetry. Epididymis must be observed as well for consistency or dilation. In the observation of an azoospermic patient, palpation of the vas deferens is especially important since its absence indicates a congenital obstructive azoospermia. Varicocele shall be excluded and a digital rectal exam is mandatory to rule out prostatic, ejaculatory duct or seminal vesicles masses and cysts.

Serum testosterone, FSH and even LH levels may aid in the prediction of OA versus NOA even though FSH may be normal in about 40% of men with primary spermatogenic failure. On the other hand, Inhibin B seems to have a higher prognostic value for normal spermatogenesis.

Typically features of distal seminal pathway obstruction are low ejaculate volume, decreased or absent seminal fructose, acidic pH and seminal vesicles dilation (anterior-posterior diameter > 15 mm). In addition to fructose, citric acid and L-carnitine (taken respectively as markers of seminal vesicle, prostate and epididymal function) may be helpful to infer the location of the obstructive process.

Concerning the etiology of OA, the main findings in transrectal ultrasonography (TRUS) include ejaculatory duct dilations, seminal vesicle abnormalities (agenesis, dilation) and prostate midline cysts (eja-

culatory duct or Müllerian cysts). Meaningful diagnostic information may be revealed in a significant number of patients by TRUS of even by scrotal US.
Notwithstanding currently there are no widespread non-invasive methods to differentiate OA from NOA. At least 60% of men with azoospermia will require a testicular biopsy to provide a definitive diagnosis as the only reliable method to distinguish them. Nonetheless, testicular biopsy is an invasive surgical procedure with possible complications such as tissue damage, bleeding and development of chronic pain. Thus, there is an urgent need for alternative, non-invasive approaches for identification of the types of male infertility and reliable biomarkers are required and will be discussed.
TEX101, a testicular germ cell-specific protein, encoded by testis expressed 101 gene (Tex101), predominantly located on the plasma membrane of germ cells during gametogenesis is not expressed in any other human tissue or cell type, including Sertoli and Leydig cells. Besides that, TEX101 is eventually cleaved and released from the cell surface of epididymal sperm while it passes through the caput epididymis. TEX101 and ECM1 (extracellular matrix protein 1) were used to develop an algorithm for non-invasive differential diagnosis of azoospermia forms (OA versus NOA). Additionally, seminal plasma levels of TEX101 could also distinguish different subtypes of NOA. TEX101 levels of 120 ng/mL or higher denote normal spermatogenesis, while levels of 5-120 ng/mL are associated with hypospermatogenesis or maturation arrest, and levels below 5 ng/ml (theoretically zero) indicate Sertoli cell-only syndrome. Clinical utility of TEX101 ELISA extends to evaluate vasectomy success and to better select patients for sperm retrieval.
Seminal prostaglandin D synthase (PGDS) level can potentially be a biomarker for assessing patency in the seminal tract in men with azoospermia and high seminal PGDS (more than 100 g/l) can potentially make the diagnosis of NOA without biopsy. Epididymal protease inhibitor (Eppin) protein is specifically secreted by testes and epididymis and it does not exist in seminal plasma of patients with OA in theory. Moreover, exosomal miRNAs in seminal plasma are potential sensitive and specific biomarkers for selecting azoospermic individuals with real chances of obtaining spermatozoa from the testicular biopsy.

RETRIEVAL, PROCESSING AND SELECTION OF SPERM FOR ICSI: WHAT SHOULD AN UROLOGIST KNOW?

Fotios Dimitriadis MD, PhD, FEBU, Assistant Professor
1st Urology Department; Aristotle University, Thessaloniki, Greece

Azoospermia occurs in about 5% of infertile men and poses a real challenge to the fertility urologist. While there are options to create happy families for azoospermic couples, such as the use of donor sperm and adoption, most couples still desire to have their own biological off-spring. Nevertheless, sperm may be present in the epididymis or the testes depending on the type of azoospermia. Advances in urology and fertility laboratory technologies allow surgical sperm retrieval in azoospermic men and achievement of live births for many, but not all azoospermic couples. A variety of surgical and non-surgical options exists for sperm retrieval in the setting of obstructive or non-obstructive azoospermia. The available techniques include percutaneous options such as percutaneous epididymal sperm aspiration (PESA) and testicular sperm aspiration (TESA), as well as open techniques that include testicular sperm extraction (TESE) and microsurgical epididymal sperm aspiration (MESA). Microdissection testicular sperm extraction (microTESE) is considered the most efficient method for surgical sperm retrieval among patients with non-obstructive azoospermia.
Assisted reproductive technologies employ sperm sorting techniques to select viable sperm from the

semen samples. Currently, standard sperm sorting methods include density gradient centrifugation, direct swim-up, and conventional swim-up. The multiple centrifugation steps during these methods, have been shown to deteriorate DNA integrity and damage sperm quality mainly through the production of reactive oxygen species. Newer technologies, such as microfluidics, electrophoresis, motile sperm organelle morphology examination, and birefringence may offer a chance to improve the selection of sperm with higher DNA integrity, normal morphology, and motility as well as improved artificial insemination outcomes.
New technologies are being developed to assist in the preparation and selection of spermatozoa in assisted reproductive technologies. To date progress has been proved to be frustrating and the developed methods have provided variable benefits in improving outcomes after ART. Maybe new strategies are required to identify the properties of those spermatozoa which naturally do reach the oviduct in order to develop more effective tests of semen quality.

RECONSTRUCTING THE URETHRA: BEST OPTIONS ON FLAPS AND/OR GRAFTS

Miroslav L. Djordjevic, MD, PhD
Belgrade University School of Medicine, Serbia

Urethroplasty, either in the treatment of congenital anomalies or urethral stricture disease, remains a great challenge in reconstructive urology and depends on the characteristics of the anomaly. Several congenital anomalies, such as hypospadias, epispadias, etc., are characterized with missing urethra and require reconstruction in primary repair. Urethral stricture disease is generally defined as stenoses that are typically long, involving broad areas of varying spongiofibrosis, and result from inflammation and/or infection, rather than trauma. Less invasive procedures such as urethrotomy, stenting or dilation continue to play a role in the treatment of urethral strictures as a first-line option in some select patients. Notable changes in surgical approach have been adopted worldwide, resulting in significant improvement of successful outcomes and simultaneously decreasing the complication rate. Selecting the appropriate technique according to disease is highly individualized and dependent on its characteristics. However, the proper selection of tissue transfer technique is paramount to success. This review, through the various clinical presentations of urethroplasty, will provide a logical, easily comprehensible approach to the appropriate selection of grafts and flaps in urethral reconstruction, followed by practical clinical guidelines.

LI-SWT AS A TREATMENT FOR ERECTILE DYSFUNCTION AFTER BILATERAL NERVE-SPARING RADICAL PROSTATECTOMY

Muammer Kendirci, MD; Professor of Urology
Department of Urology, Istinye University Faculty of Medicine, Liv Hospital Ulus, Istanbul, Turkey

Prostate cancer is the most commonly diagnosed and treated solid malignancy in men all over the world. Treatment options for prostate cancer include radical prostatectomy (open, laparoscopic or robotic), hormonal ablation, external beam radiation, and brachytherapy. From a urological perspective, radical prostatectomy is the recommended treatment for most cases of organ-confined disease. Men diagnosed with prostate cancer who elect surgical extirpation need to be appraised of the potential morbidities, including urinary incontinence and erectile dysfunction (ED). When selecting a treatment

for prostate cancer, the maintenance of quality of life is the principle concern for many of the patients. This finding has contributed to an increasing focus on understanding the pathophysiology of post--prostatectomy ED and the idea of instituting prophylactic measures for prevention and early recovery from ED.

The incidence of ED in men following radical prostatectomy (RP) has been reported to range from 16 to 82%[1]. The introduction of the nerve-sparing radical prostatectomy (NSRP) in 1982 by Walsh and Donker as a means to preserve erectile function has been embraced globally and increased the acceptance of the surgical approach for prostate cancer treatment. Although recent outcomes have reported better erectile function and continence preservation using robotic approaches, there is no guarantee that erectile function will be preserved. Preoperative erectile function is strongly correlated with patient age and a number of co-morbidity conditions, such as diabetes, hypertension, and cardiovascular disease. As the recovery rates of erectile function after NSRP are conversely correlated with the patient's age and the best postoperative potency rates are more likely achieved in men younger than 65 years of age, the age of the candidates for nerve-sparing surgery is a very important factor[2]. Associated co-morbidities such as diabetes, hypertension, hypercholesterolemia, ischemic heart disease, and smoking can impact preoperative erectile function and postoperative recovery of erections. Furthermore, determination of clinical stage, grade, and location of the tumor are recognized factors that predict the likelihood of developing ED postoperatively. Men who report some degree of ED or use phosphodiesterase 5 (PDE5) inhibitors prior to surgery are more likely to develop severe ED postoperatively.

After bilateral NSRP, erectile function is uniformly impaired in the early postoperative period because of the development of neuropraxia. Neuropraxia is caused by relative trauma of the cavernosal nerves during surgical dissection of the neurovascular bundles. Chronic hypoxia and denervation are believed to be the initiating factors for apoptosis, which in turn increases the deposition of connective tissue. Postoperative decrease in penile length is a direct consequence of increased corporeal fibrosis.

Due to the accumulating preclinical animal and clinical human data, either daily or on-demand use of PDE5 inhibitors may have a role for early recovery of erectile function and treating ED post-RP. Early postoperative treatment regimens using intracorporal injections of vasoactive agents or PDE5 inhibitors are currently recommended by a number of authorities as a means to increase nocturnal erections and oxygenation of the cavernosal tissues. An added benefit is that successful intracorporeal injection therapy soon after radical prostatectomy may allow for resumption of sexual activity and improved couple satisfaction. Vacuum erection devices (VED) provide a safe, cost-effective, non-invasive, non--medical alternative to intracavernosal injection therapy in the post-prostatectomy ED patient.

Low-intensity extracorporeal shock wave therapy (LI-ESWT) is an emerging therapy for ED. Its ability to improve erectile function has been shown in patients with vasculogenic ED by shown a number of randomized-controlled trials against sham procedures. However, the efficacy of LI-ESWT in ED in men who undergo NSRP is still unknown because Post-RP ED was excluded from nearly all clinical studies; it has been investigated in only a few small single-arm trials. Vasculogenic disorders are the main study object of clinical LI-ESWT for ED; post-RP ED is rarely referred to in the literature. Current evidence that robustly supports the application of LI-ESWT for ED secondary to RP is therefore lacking. The capacity of LI-ESWT to improve functional outcome after nerve injury has been observed in neurological diseases. Its neuroprotective and/or regenerative effects are considered to be related to local angiogenesis, modulated inflammation, continuous expression of neurotrophic factors, and reduction of free radicals. However, the exact mechanisms are still under investigation. Vascular endothelial growth factor (VEGF) is an angiogenic and neurogenic factor, and might have an important

role in neural recovery by stimulating endothelial cells to promote neovascularization and neural cells to induce neuroprotective effects[3]. Yahata et al. demonstrated that LI-ESWT suppressed cell death and axonal damage by inducing VEGF protein expression in various neural cells (neurons, astrocytes, and oligodendrocytes) and enhancing angiogenesis in impaired neural tissue; it consequently improved locomotor and sensory functions after SCI in rat model[4].

Neurotrophic factors enhance nerve regeneration processes and functional recovery in animal models. LI-ESWT could release a range of neurotrophic factors, such as brain-derived neurotrophic factor (BDNF), which plays a central role in neuronal development, maturation, and survival after injury. LI-ESWT may stimulate the expression of BDNF in penile tissue through activation of PERK/ATF4 signaling pathway[5]. Schwann cell BDNF expression was also increased after LI-ESWT[5].

In a pilot study by Frey et al.[6] that included 16 patients, each with at least 1 year's history of bilateral NSR-P-associated ED, subjects received two LI-ESWT sessions every other week for 6 weeks. Each session included 1000 shock waves with energy densities of 20, 15, and 12 mJ/ mm2, applied to the root of the penis, to the shaft, and at a few millimeters proximal to the glans, respectively, for a total of 3000 shock waves and frequency of 5 Hz. This study concluded that LI-ESWT might ameliorate EF, with the median improvement to five-item IIEF scores of 3.5, at 1 month and 1 year after treatment, respectively.

LI-ESWT can improve EF in post-RP ED rat models. Angiogenesis and prevention of penile tissue apoptosis induced by the therapy contributed to EF recovery to some extent[7]. Although the ability of LI-ESWT to promote cavernous nerve regeneration lacks direct and consistent evidence, some pro-neurogenic changes, such as Schwann cell activation, release of neurotrophic factors, and penile stem or progenitor cell recruitment and activation were observed in penile tissue after LI-ESWT. The results of LI- ESWT for neurological diseases also indirectly support its promotion of nerve regeneration in post-RP ED[7]. Although there have been supporting evidences derived from preclinical studies for the benefit of LI-ESWT in NSRP, the potential use of LI-ESWT in NSRP-related ED, randomized-clinical trials are needed for its clinical routine application.

References

1. Kendirci M, Bejma J, Hellstrom WJ. Update on erectile dysfunction in prostate cancer patients. Curr Opin Urol. 2006 May; 16(3):186-95.

2. Kendirci M, Hellstrom WJ. Current concepts in the management of erectile dysfunction in men with prostate cancer. Clin Prostate Cancer. 2004 Sep; 3(2):87-92.

3. Jin K, Zhu Y, Sun Y, Mao XO, Xie L, Greenberg DA. Vascular endothelial growth factor (VEGF) stimulates neurogenesis in vitro and in vivo. Proc Natl Acad Sci USA. 2002; 99: 11946–50.

4. Yahata K, Kanno H, Ozawa H, Yamaya S, Tateda S, Ito K, et al. Low-energy extracorporeal shock wave therapy for promotion of vascular endothelial growth factor expression and angiogenesis and improvement of locomotor and sensory functions after spinal cord injury. J Neurosurg Spine. 2016; 25: 745–55.

5. Wang B, Ning H, Reed-Maldonado AB, Zhou J, Ruan Y, Zhou T, et al. Low-intensity extracorporeal shock wave therapy enhances brain-derived neurotrophic factor expression through PERK/ ATF4 signaling pathway. Int J Mol Sci. 2017; 18: 433.

6. Frey A, Sønksen J, Fode M. Low-intensity extracorporeal shock wave therapy in the treatment of postprostatectomy erectile dys- function: a pilot study. Scand J Urol. 2016; 50: 123–7.

7. Zou ZJ, Liang JY, Liu ZH, Gao R, Lu YP). Low-intensity extracorporeal shock wave therapy for erectile dysfunction after radical prostatectomy: a review of preclinical studies. Int J Impot Res. 2018 Feb; 30(1): 1-7.

CURRENT AND EMERGING TREATMENTS FOR PREMATURE EJACULATION

Mustafa Faruk Usta M.D., Professor of Urology
Akdeniz University School of Medicine; Department of Urology, Section of Andrology; Antalya-TURKEY

Recently it has been reported that Premature Ejaculation (PE) is one of the most commonly encoun-

tered male sexual dysfunction, with prevalence ranging between 20% and 30% in the sexually active male population[1]. Furthermore, studies have also revealed that PE may have a detrimental impact on quality of life of patients and their partners as well. Despite its high prevalence, in the literature there are several definitions of PE made by different proffessional organizations[1]. In 2007 The International Society for Sexual Medicine (ISSM) committee defined lifelong PE as 'a male sexual dysfunction charecterized by ejaculation which always or nearly always occurs prior to or within the first minute of vaginal penetration and the inability to delay ejaculation on all or nearly all vaginal penetrations; and negatively personal consequences, such as distress, bother, frustration, and/or the avoidance of sexual intimacy.[2,3]. However, in April 2013 again the ISSM agreed on a unified definition of both acquired and lifelong PE as 'a male sexual dysfunction charecterized by ejaculation which always or nearly always occurs prior to or within about one minute of vaginal penetration from the first sexual experiences (lifelong PE), or a clinically significant and bothersome reduction in latency time, often to about 3 minutes or less (acquired PE), and the inability to delay ejaculation on all or nearly all vaginal penetrations, and negative personal consequences, such as distress, bother, frustration and/or the avoidance of sexual intimacy[2,4].

As a result of non-homogen data and not well defined physiology associated to ejaculation and pathophysiology of ejaculatory dysfunction, the most appropriate therapeutic option for PE therapy, was considered earlier as an interest related to the field of Psychosexology. In the late of 1990's Waldinger and colleagues reported the neurobiological-genetic aspect of PE, followed by several studies revealing the research with various selective serotonin reuptake inhibitors (SSRIs)[5]. After the first placebo-controlled study of paroxetine, the efficacy of numerous SSRI's was assessed and have been used for off-label treatment of PE. Furthermore, short-acting SSRI namely Dapoxetin, topical anesthetics, and more recently tramadol have been used as on- and off-label therapeutic options for the treatment of PE.

In the present paper we aimed to provide an overview related to the efficacy of current treatment options, widely used for the treatment of PE.

1) Topical Anesthetics (TAs): TAs have been widely used 'off-label' for the treatment of PE. The most commonly used preparation is combined lidocaine and prilocaine cream (EMLA; AstraZeneca). Additionally a combined lidocaine and prilocaine sprey (TEMPE; Plethora Solutions) has been investigated in several studies but has not received regulatory approval yet. In the literature the efficacy of TAs has been investigated mostly in studies which include combination strategies. In one study the efficacy of on demand (OD) application of lidocaine gel 2.5% was compared to paroxetine OD, tramadol OD, sildenafil OD and placebo. The results of this study showed that lidocaine induced a significant increase in IELT (from 54.2s to 278 s; $p<0.05$) compared to placebo[6]. In another study be Busato et al it has been shown that EMLA treatment OD significantly increased mean Intravaginal Ejaculation Latency Time (IELT) (from 1.49 to 8.45 min; $p<0.001$) compared to placebo (from 1.67 to 1.95 min; $p>0.05$)[7]. In addition the efficacy of TEMPE OD was assessed in three company-sponsored studies. Dinsmore showed that the mean change in IELT from baseline was 2.4 times higher for TEMPE therapy group than for placebo ($p<0.001$)[8]. In a phase-3, multicentre, double blind, placebo controlled study, again Dinsmore et al showed that the geometric mean IELT increased from a baseline 0.6min in the TEMPE and placebo group to 3.8 min and 1.1 min over the 3-month treatment period, representing 6.3 and 1.7-fold increases in adjusted geometric mean IELT, respectively ($p<0.001$)[9].

2) Tramadol: Tramadol is an opioid pain medication used to treat moderate and severe pain. The efficacy of tramadol has been evaluated in several studies. All studies showed that tramadol OD significantly increased IELT compared to placebo[1]. Furthermore in another study the efficacy of tramadol was also assessed in a dose dependent fashion. In this study the patients were randomized 1:1:1 to receive pla-

cebo or 62 or 89mg tramadol as an orally disintegrating tablet (ODT). The results of this study showed that Tramadol ODT caused to a significant increase in median IELT compared to placebo. The increases were 0.6 min (1.6-fold) for placebo, 1.2 min (2.4 –fold) for 62 mg tramadol ODT and 1.5 min (2.5-fold) for 89 mg tramadol ODT (all $p<0.001$)[10]

3) SSRIs: SSRIs are a class of drugs used in the treatment of major depressive disorder and anxiety disorders. Castiglione et al reviewed the efficacy of SSRIs in their systemic analysis[1]. Fourteen published studies testing SSRIs were included in this review and among these studies 11 investigated the efficacy of long-acting SSRIs (paroxetine, fluoxetine, sertraline, citalopram, and fluvoxamine; while three investigated the efficacy of the short-acting SSRI dapoxetine[1]. Long-acting SSRIs have been used in daily or OD dose regimens. In the review by Castiglione et al six studies compared IELT between daily SSRI and placebo groups. Five different SSRIs namely paroxetine 20mg, sertraline 50mg, fluoxetine 20mg, citalopram 20mg, and fluvoxamine 100mg have been investgated in this review[1]. It has been reported that all these drugs were effective in delaying ejaculation in men with PE. Additionally, it has been reported that daily paroxetine 20mg caused to the longest ejaculatory delay. Furthermore three studies in the same review explored the efficacy of OD use of SSRIs, administered 3-6h before planned sexual relation. OD treatment with citalopram 4-6 hours before sexual intercourse was more effective than placebo ($p<0.001$). In another study it has been shown that OD paroxetine was superior to placebo in increasing IELT values ($p<0.001$).

Dapoxetine hydrochloride is a short-acting SSRI with a pharmacokinetic profile favorable for OD treatment for PE. It should be noted here that Dapoxetine is currently the only drug approved by the European Medicines Agency (EMA) for OD treatment for PE (1). Up to now the efficacy of dapoxetine OD on IELT was evaluated in several studies. However there are three large randomized, doublr-blind, placebo-controlled, industry-sponsored phase 3 studies.

The efficay of 30 mg and 60 mg dapoxetine OD was assessed in two 12-week placebo-controlled studies including 1958 PE patients in the USA. The results of this study showed that 30 mg and 60 mg Dapoxetine doses significantly increased IELT compared to placebo (up to 3.6-fold over baseline; $p<0.001$)[11]. Furthermore Buvat et al reported the results of a phase 3 study with 618 PE patints. In this study it has been shown that IELT values increase from 0.9min at baseline to 1.9, 3.2, and 3.5 min for placebo and 30mg and 60mg dapoxetine, respectively ($p<0.001$)[12]. On the other hand, dapoxetine provided a good safety profile and reasonable prevalence of side effects, with a dose dependent profile.

Medical treatment for PE still remains a challenge in the field of male sexual dysfunction. Although, over the past 30 years several treatment options have been investigated in several studies, most of these studies are characterized by limitations such as low sample size, absence of placebo arms and unclear procedures for randomization. It should be mentioned here that several drugs have entered the PE treatment market without an ideal scientific basis for their efficacy. Even though there is only one drug (dapoxetine) approved for PE treatment, several drugs are available for off-label use. Another important point is that the definition of PE has changed several times over the past few years and this caused to a heterogenous body of literature with several pharmacological studies using different patient selection criterias. Actually, an increase in IELT has been suggested as the main goal of PE therapy in most of the studies. However, contraversely it has also been reported in some studies that the increase in IELT is not necessarily clinically meaningful for patients. In fact, this is also an important point which we need to keep in mind when we evaluating the results of studies investigating the efficacy of drugs for PE therapy.

In summary, Dapoxetine is currently the only agent which gain regulatory approval for the treatemt of PE. On the other hand, sevreal other drugs are still used off-label for the treatment of PE. It is obvious

that for making more scientific comments we need more well designed studies with large number of patients.

References:
1. Castiglione F et al: Current Pharmacological Management of Premature Ejaculation: A Systematic Review and Meta-analysis. Eur Urol,2016; 69: 904-916
2. Zhang X et al: The Relationship between Self-Estimated Intravaginal Ejaculatory Latency Time and International Prostate Symptom Score in Middle-Aged Men Complaining of Ejaculating Prematurely in China. J Sex Med 2015; 12:705-712
3. McMahon CG et al: An evidence-based definition of lifelong premature ejaculation: Report of the International Society for Sexual Medicine (ISSM) ad hoc committee for the definition of premature ejaculation. J Sex Med 2008;5:1590–1606.
4. Serefoglu EC et al: An evidence-based unified definition of lifelong and acquired premature ejaculation: Report of the second International Society for Sexual Medicine Ad Hoc Committee for the Definition of Premature Ejaculation. J Sex Med 2014;11:1423–1441.
5. Waldinger MD et al: Premature ejaculation and serotonergic antidepressants-induced delayed ejaculation: the involvement of the serotonergic system. Behav Brain Res 1998;92: 111–118.
6. Gameel TA et al: On-demand use of tramadol, sildenafil, paroxetine and local anaesthetics for the management of premature ejaculation: a randomised placebocontrolled clinical trial. Arab J Urol 2013;11:392–397.
7. Busato W and Galindo CC: Topical anaesthetic use for treating premature ejaculation: a double-blind, randomized, placebo-controlled study. BJU Int 2004;93:1018–1021.
8. Dinsmore WW et al: Topical eutectic mixture for premature ejaculation (TEMPE): a novel aerosoldelivery form of lidocaine-prilocaine for treating premature ejaculation. BJU Int 2007;99:369–375.
9. Dinsmore WW et al: PSD502 improves ejaculatory latency, control and sexual satisfaction when applied topically 5 min before intercourse in men with premature ejaculation: results of a phase III, multicentre, double-blind, placebo-controlled study. BJU Int 2009;103:940–949.
10. Bar-Or D et al: A randomizeddoubleblind, placebo-controlled multicenter study to evaluate the efficacy and safety of two doses of the tramadol orally disintegrating tablet for the treatment of premature ejaculation within less than 2 min. Eur Urol 2012;61:736–743.
11. Pryor JL et al: Efficacy and tolerability of dapoxetine in treatment of premature ejaculation: an integrated analysis of two double-blind, randomised controlled trials. Lancet 2006;368:929–937
12. Buvat J et al: Dapoxetine for the treatment of premature ejaculation: results from a randomized, double-blind, placebo--controlled phase 3 trial in 22 countries. Eur Urol 2009;55:957–968

PDE5 INHIBITORS AS AN ADJUNCT TOOL FOR THE THERAPEUTIC MANAGEMENT OF MALE INFERTILITY

Nikolaos Sofikitis, MD, Ph.D., D.M.Sci, Professor of Urology;
Ioannina University School of Medicine, Greece

Peritubular myoid cells are positive for PDE5 expression. Leydig cells are positive for PDE11A, PDE4B, PDE5, PDE8A and PDE11. Sertoli cells are known to be positive for PDE1, PDE3 and PDE4 expression. Human epididymis is known to be positive for PDE3 and PDE5 expression. Vascular monocytes within the testis are positive for PDE11 and PDE5. Vas deferens is positive for PDE5. Prostate is positive for PDE5a, PDE11A4 and PDE11A1. It is logical to hypothesize that administration of inhibitors of PDE5 may affect testicular endocrine and exocrine function, epididymal function, prostatic secretory function and prostatic physiology. However it should be emphasized that PDE5 inhibitors may additionally inhibit to a smaller degree other phosphodiesterase families within the testis. For instance, PDE5 inhibitors additionally inhibit to a smaller degree PDE11, PDE4, PDE8, and PDE3. Therefore administration of PDE5 inhibitors may affect several cellular subpopulations within the male reprodive tract.
Spermatids are positive for PDDE11, PDE4A, PDE4D, PDE1A, and PDE1C. Spermatozoa are positive for PDE1A, PDE3A, PDE4, PDE5, PDE6, and PDE10A.
Spermatogonia are positive for PDE11A, PDE1, and PDE2. Primary sprermatocytes are positive for

PDE11, PDE3, PDE4, and PDE1C.

The above localization of selected PDE5-families explains the enhanced Leydig cellular secretory function and the increased Sertoli cellular secretory function after administration of either sildenafil or vardenafil. In fact, the increased Leydig cellular secretory function post-sildenafil administration has been proven by the increased INSL3 production by human Leydig cells after sildenafil administration. On the other hand, the increased Sertoli cellular secretory function post-vardenafil administration has been proven by the increased androgen-binding activity/content produced by human Sertoli cells after vardenafil administration. Increased peripheral serum testosterone concentration has been demonstrated post-avanafil administration, as well.

The enhanced Leydig or Sertoli cell secretory function after sildenafil or vardenafil administration may result in increased intraepididymal lumen concentrations of testosterone or androgen binding protein allowing optimal epididymal sperm maturation process. The final result may be an increase in sperm motility after administration of either sildenafil or vardenafil. An alternative mechanism to explain the beneficial effects of sildenafil on sperm motility may be the enhanced prostatic secretory function established after administration of sildenafil. In fact post-sildenafil administration increased concentrations of markers of prostatic secretory function have been demonstrated. Therefore a second attractive hypothesis may be that administration of sildenafil, acting on prostatic PDE5, increases prostatic secretory function with an overall result a positive effect on sperm motility. Such a positive effect of sildenafil, vardenafil, or avanafil on sperm motility has been demonstrated very vividly in our laboratory and in other independent laboratories. In a previous study the beneficial effects of avanafil on sperm motility were attributed to the longer length of sperm midpiece post-avanafil administration. It is well known that the sperm midpiece is the “battery” of the spermatozoon and therefore positive effects of avanafil on the sperm cytoskeleton affecting the sperm motility have been demonstrated in the above study. On the other hand, other groups did not demonstrate a positive effect of sildenafil on the standard parameters of semen analysis.

It appears that the above pharmaceutical agents do not affect serum reproductive hormonal levels. On the other hand, a recent report has indicated that avanafil administration increases the peripheral serum testosterone levels.

Tadalafil is known to inhibit to a certain degree the PDE11. PDE11 is highly expressed in the testis, prostate, and developing spermatozoa. PDE11 knockout mice display reduced sperm concentration, rate of forward progression, and percentage of live spermatozoa. Pre- ejaculated sperm from the above mice display increased premature/spontaneous capacitance. In the above study from UK the authors emphasize that agents, like tadalafil, that inhibit PDE11 may have the potential to disrupt regulation of spermatozoa cAMP, and as a result may have detrimental effects on sperm physiology. A study from Andria, Italy has demonstrated that once-a-day tadalafil administration improves the spermogram parameters in fertile patients. However the above study has been criticized because the respective results refer to fertile patients. It would be a more clinically significant study, a clinical trial evaluating the effects of tadalafil on the reproductive potential of infertile patients since a small impairment in sperm qualitative and quantitative parameters may not be clinically important in fertile patients, however, an impairment in sperm qualitative and quantitative parameters may have more serious consequences in infertile patients (especially if they do not want to participate in assisted reproductive technology programs). In another communication from New Orleans, LA, USA, it has been proven that there are not deleterious effects of nine months of daily tadalafil 20 mg on spermatogenesis or hormones related to testicular function in men elder than 45 years old. In a similar fashion, the above study cannot be unequivocally interpreted as a clinical trial establishing a safety profile for tadalafil due to the barrier

that the latter study has employed men with relatively high (or normal) sperm concentration, normal sperm motility, and normal sperm morphology. In another different study from New Orleans, LA, USA, it has been demonstrated that chronic daily administration of tadalafil at doses of 10 and 20 mg for six months has no adverse effects on spermatogenesis on reproductive hormones in men older than 45 years. However, for subjects to be enrolled in the latter study, semen samples had to have certain minimum normal values based on WHO criteria. Thus the latter study has similar, as above stated, limitations due to the fact that men with male factor infertility and at least one abnormal parameter of the semen analysis had not been included. In an in vitro study from Cairo, Egypt, it has been shown that semen samples recovered from asthenozoospermic men and subsequently treated with tadalafil concentration equal to 1 mg/ml demonstrate significant increase in sperm progressive motility, whereas, specimens treated with 4 mg/ml tadalafil concentration demonstrate a significant decrease in sperm motility. Scientists suggested that the effect of tadalafil on sperm motility in vitro can be explained by a stimulation of the cAMP-protein kinase A pathway, whereas the inhibitory effect of this substance on PDE11 may also contribute to the effect of tadalafil on sperm motility. All the above studies should be coupled with the reports that tadalafil has been shown to inhibit human recombinant PDE11A1 activity at therapeutic concentrations, which is highly expressed in the testis and prostate, and its important function in spermatogenesis has been documented. On the other hand, several studies have indicated that sildenafil and vardenafil are one-two orders of magnitude more selective for PDE5 than PDE11 compared with tadalafil. The later studies offer a safety profile for sildenafil and vardenafil for sperm physiology, in contrast to the existing concerns on the influence of tadalafil on sperm parameters in men with abnormal values in semen parameters.

The international literature supports that administration of vardenafil in men with non-obstructive azoospermia does not alter the sperm recovery rate after testicular biopsy procedures. Thus non-obstructed azoospermic men with erectile dysfunction may use vardenafil without any consideration for the outcome of a subsequent testicular biopsy procedure.

It should be emphasized that the positive effects of PDE5 inhibitors on erectile function may assist a subpopulation of men who attempt to produce a semen sample at the day of oocyte pick-up (in assisted reproductive trials), to reduce their stress and produce a semen sample of better quality. In these cases the production of a semen sample with higher quantitative or qualitative sperm parameters may be due to the reduction of the stress during the ejaculation process and the subsequent achievement of higher sexual satisfaction. Several studies from Yonago, Japan, have indicated that the higher the sexual satisfaction is, the higher the semen quality is. In addition, in the above studies, it has been shown that semen samples selected via sexual intercourse are of higher quality than semen samples collected via masturbation. Thus administration of vardenafil, or sildenafil, or avanafil may be indicated in men attempting to produce a semen sample during the day of the female partner- oocyte pick-up.

PDE5 is additionally expressed in epididymis. It has been demonstrated that no alterations occur in the epididymal secretory function by administering vardenafil. Additionally, it has been observed that in oligozoospermic infertile men treated with sildenafil, no increase in semen levels of -glucosidase (a marker of epididymal function) is found. Furthermore, the effect of sildenafil on epididymal semen parameters has been evaluated in Sprague-Dawley rats. It has been demonstrated a significant increase in epididymal sperm motility and concentration compared to the control group.

PDE5 is expressed in the seminal vesicles, as well. The outcome of different studies of PDE5 inhibitors on the seminal vesicular physiology is controversial. The effect of sildenafil on the seminal vesicles in oligozoospermic men has been evaluated. Comparing semen samples before and after sildenafil treatment, no significant difference in seminal fructose levels, which is a marker of seminal vesicular func-

tion, has been observed. In an interesting study, the ultrasound alterations of seminal vesicle in infertile diabetic patients treated with tadalafil for three months have been studied. Compared to placebo, a significant reduction in seminal fundus/body ratio, a higher pre- and post-ejaculation anteroposterior diameter, and a significant increase in seminal ejection have been observed.
The potential effect of sildenafil on spermatozoal ability to undergo capacitation process has been investigated. The investigators demonstrated that several concentrations of sildenafil may activate the capacitation process of washed spermatozoa. In another study, the impact of sildenafil on sperm acrosomal reaction has been evaluated. Spermatozoa were exposed to different doses of sildenafil. The investigators demonstrated that sildenafil affected the sperm acrosomal reaction with enhanced percentage of acrosomally reacted spermatozoa in comparison with the control specimens. It has been demonstrated that cGMP directly opens cyclic nucleotide-gated channels for calcium entry into the spermatozoa initiating the acrosome reaction.
We may suggest that administration of sildenafil, vardenafil, or avanafil may be recommended for semen production during assisted reproductive technology trials when the stress of the male is a great barrier for the production of a semen sample. Considering that randomized controlled trials provide positive results for the influence of sildenafil, or vardenafil, or avanafil on sperm motility, it may be suggested that the above pharmaceutical agents may have a beneficial role in the alleviation of asthenospermia in idiopathic infertile men. Definitely, additional research efforts are justified to further investigate the influence of PDE5 inhibitors on sperm qualitative, quantitative, and functional parameters and on semen physiology. Furthermore it appears to be of great clinical importance to further investigate the role of PDE11 in spermatogenesis process, epididymal sperm maturation process, and the overall sperm fertilizing capacity taking into serious consideration a) that PDE11 is highly expressed in spermatogonia, spermatocytes and spermatids in addition to its expression in Leydig cells, and b) that studies from Kent, U.K. have suggested that agents that inhibit PDE11 level have the potential to disrupt regulation of spermatozoal cAMP, and as a final result may have detrimental effects on sperm physiology and may lead to a reduced fertilization ability according to the investigators opinion.

SPERM RETRIEVAL IN SPECIFIC SITUATIONS

SPERM RETRIEVAL IN PATIENTS WITH HIV, HEPATITIS B AND C, HTLV: WHAT IS NEW?

Nuno Louro, MD, Urology Specialist
Hospital Geral de Santo António, Centro Hospitalar do Porto, Portugal

A significant part of people living with chronic viral infections is of reproductive age, and their reproductive wishes are similar from those of the general population. Nevertheless, these individuals experience some barriers in the access to assisted reproductive technology, mainly based on personnel transmission concerns, crosscontamination concerns, lack of expertise among clinicians in handling such specimens, and high cost of the facilities recommended to treat these couples. Amongst the viral infections proposed to be dealt with in this session, human immunodeficiency virus (HIV) infection has focused most of the attention and we have much more scientific literature on this issue than concerning any of the other viruses. It is now well known that the use of highly active anti-retroviral therapy (HAART) and pre-exposure prophylaxis (PrEP) can significantly reduce the rates of transmission of the infection to the partner and the use of density gradient sperm washing combined with intrauterine insemination (IUI) or in vitro fertilization (IVF) is well established in the assisted reproductive laboratory. Less is known on the management of the azoospermic patient with HIV infection. Although it seems

appropriate to deal with these patients the same way as the general population when the viral load is undetectable and the technique of density gradient washing has been successfully applied to testicular specimens, the scientific literature is still scarce. The case with hepatitis B virus (HBV) is quite different. Although HBV concentration can be decreased during ex vivo semen processing, HBV integrated into host cells cannot be eliminated, so sperm washing techniques are not as effective risk-reduction strategies as is seen in HIV infection and ART is not indicated with the sole purpose of reducing the transmission of the disease. The reproductive treatments strongly rely on the ability to prevent the infection in the female partner and child by ascertaining her vaccination status, since the vaccine has a greater than 95% of efficacy in preventing the infection. We do not have a vaccine to prevent hepatitis C virus (HCV) infection, but we do have highly active antiviral agents with cure rates greater than 95%. Unfortunately these drugs are quite expensive, which limits their global access. Similarly to HIV infection, and since HCV is only present in the seminal plasma, sperm-washing will eliminate the virus allowing the couple to pursue with ART. Nevertheless, these couples should be strongly encouraged to submit first to medical treatment of the infection and after 6 months of the completion of therapy and confirmation of cure, the couple could be managed as any other couple with infertility. In regard to HTLV infection the literature is very poor. The only evidence available comes from case reports of patients treated with density gradient sperm washing techniques, similarly to HIV infected patients, with favourable outcomes.
The possibilities of reproductive treatments in this specific population with chronic viral infections has changed in the last years, and we, as health practitioners have the duty to make sure that these couples have access to the best care possible regarding their reproductive goals while obviously minimizing the risks of transmission to partner and offspring.

HEMATOSPERMIA: CURRENT EVALUATION AND TREATMENT MODALITIES

Oleg Ivanovich Apolikhin
Corresponding Member of the Russian Academy of Sciences, Chief Specialist of the Russian Ministry of Health for Reproductive Health, Director of N.Lopatkin Scientific Research Institute of Urology & Interventional Radiology - branch of the federal state budgetary institution “National Medical Research Center of Radiology” of the Ministry of health care of Russia.

Hemospermia is a blood in the ejaculate, due to anatomical or functional disorders of the male gonads, urethra and the vas deferens. Hemospermia in young men could be a sign of inflammation of seminal vesicles, acute prostatitis.
The appearance of hemospermia is frightening and alarming for all patients. Up to 77% of patients go to the doctor after 1 or 2 episodes.
Hemospermia might be divided to several categories: persistent (constant, true) (Hemospermia vera); periodic (false) (Hemospermia spuria) and chronic. However, there is still no answer to the question, how long should the symptoms last, so that you can define hemospermia as chronic? Clear definitions of this concept does not exist.
The etiology of hemospermia is very diverse.
Congenital anomalies
- anomalies of seminal vesicles / cyst of the vas deferens

Inflammatory
- urethritis, prostatitis, epididymitis
- tuberculosis of the genitourinary system

- cytomegalovirus, HIV-infection
- schistosomiasis, hydatidic echinococcosis
- condylomas of the urethra and meatus
- urinary tract infections

Obstruction
- calcifications (concretions) of the prostate, seminal vesicles and vas deferens cyst of the seminal vesicle (as the outcome of inflammation)
- diverticula of the vas deferens
- strictures urethra
- cysts urethra
- benign prostatic hyperplasia

Tumors
- prostate
- bladder
- seminal vesicles
- urethra
- testicles, epididymis
- melanoma

Vascular
- varicose veins of the prostate gland
- capillary angioectasias
- hemangiomyveins of the posterior urethra
- prolonged coitus and masturbation

Injuries
- pelvis
- testicles
- Autoclassification
- transrectal ultrasound (TRUS)
- arteriovenous fistula

System
- hypertension
- hemophilia
- hemorrhagic purpura
- scurvy
- blood coagulation system diseases
- chronic liver disease
- renovascular diseases
- leukemia
- lymphomas
- cirrhosis of the liver
- amyloidosis

In case of inflammatory etiology, chronic bacterial prostatitis or Sexually Transmitted Infections (STI) can cause hemospermia. The most common infectious agents are Herpesvirus type II (42%), . Trachomatis (33%), Enterococcus (17%), U. urealyticum (8%).

If Hemospermia is suspicious for traumatic and iatrogenic etiology, it is important to differentiate

macrohematuria from Hemospermia. The pathological mechanisms of of traumatic hemospermia can also be different: direct; during/after intercourse (increased pressure); evacuation disorder (high blood pressure after prolonged abstinence, «erotica sive sympathica»). As iatrogenic causes includes prostate biopsy (6% - 13%), radiation therapy (HIFU), Internal stent offset, extracorporeal shock wave lithotripsy of the distal ureteral stones(26%). Sometimes Hemospermia can be as a manifestation of cardiovascular disease, for example, in case of severe hypertension in youth. In other case Hemospermia was described as a rare form of Zinner syndrome (cyst of the seminal vesicle, ipsilateral renal agenesis, obstruction of the vas deferens). In men over 40, Hemospermia can be a sign of prostate cancer involving the process of seminal vesicles. According to various data, this occurs in 0,5-18% cases.
The doctor should perform a comprehensive examination to determine the possible cause of Hemospermia. This examination should include detailed anamnesis, general physical examination and digital rectal examination. The following tests should also be provided: clinical blood test, urinalysis, coagulogram, PCR-diagnostics for STI, cytology, evaluation of liver function, biochemical blood analysis sperm analysis.
About 70 – 80 % cause Hemospermia is still not detecting. But, fortunately, there is a spontaneous resolution within a month in 60% of cases

MALE INFERTILITY: TREATMENT CONTROVERSIES
IS THERE A ROLE FOR ROBOTIC SURGERY IN THE ALLEVIATION OF MALE INFERTILITY TODAY?

Pedro Vendeira, MD, PhD, FECSM, Urology Specialist
President of the Portuguese Society of Andrology, Sexual Medicine and Reproduction
Coordinator of the Urology Department of Saúde Atlântica, Clínica do Dragão, Oporto, Portugal

As technology brings new tools to the operating room, there is increasing pressure to ensure patient safety and cost-effectiveness. Robot-assisted laparoscopic surgery has evolved since its inception in 1985 to its current state in the form of the da Vinci surgical system (Intuitive Surgical, Sunnyvale, California). This technology offers some advantages, including a 3-dimensional view of the operative field, "wristed" instruments that facilitate intracorporeal suturing, elimination of surgeon tremor, and ergonomic benefits among others[1].
What about male infertility and Andrology? Is the future Robotic…?
The first human case series on robotic-assisted microsurgical vasectomy reversal was published in 2004 by Fleming et al[2], and suggested we were facing a greater ease surgical technique, precision of suture placement and a shorter learning curve.
These findings gave further support for investigation and future developments in andrological surgical procedures. The 0 degree camera of the da Vinci robotic platform provides up to 10-15X magnification. The incorporation of an additional camera system (VITOM) as a fifth arm leads to a better (up to 16-20X) magnification. The TilePro software system allows viewing of 3 simultaneous realtime images. These simultaneous viewing capabilities also allow microsurgeons to evaluate seminal fluid or tissues without having to stop operating[3]. In 2010, Parekattil et al[4] published a series of robotic vasectomy reversals, comparing the outcome results of 20 patients who underwent a robotic procedure and 7 men who underwent the same procedure by microsurgery using a three-layer technique. Vasal patency was 100% in both groups and the length of the operating time actually favoured the robotic approach (109min vs 128min). This same group[5] later reported a larger series with 155 patients with patency rates of 96% in the robotic group and 80% in the microsurgical group. In 2015 Kavoussi et al[6] publi-

shed their series with 27 microsurgical and 25 robotic-assisted vasectomy reversal cases, finding that there was no significant difference concerning overall patency rate (89% vs 92%), mean sperm concentrations at 6 weeks (28x106 ml-1 vs 26x106 ml-1) and mean operative time (141min vs 150min). Accepted advantages in robotic-assisted surgery include shorter operative time, increased patency rates (still limited data on this matter that needs further larger studies), and a decreased learning curve when compared to traditional microsurgery, together with an increased ease of placing the needle and counteracting surgeon tremor. This technology also allows for a convenient training tool for residents and fellows. The newer robotic platforms allow for a dual surgeon consoles providing an experienced surgeon to operate with a trainee simultaneously[7]. Disadvantages include a higher cost, the necessity of a specialized surgical team, low availability of microsurgical instruments and inferior magnification (10–15×) compared to a microscope (20–30×). The use of increased magnification is of particular importance when performing the more challenging vasoepididymostomy, and this is probably the reason why the current literature mainly describes the vasovasostomy robotic procedure[8]. Unlike robotic surgery, surgeons now have decades of collective experience with microsurgery, and a high level of skills and efficiency has been reached. However new optical refinements will further enhance the robot capabilities in the future. It remains to be seen if surgical quality and efficacy can be improved.

Robotic-assisted microsurgery also allows for novel microsurgical approaches. It is now possible to perform microsurgery in locations of the body that would otherwise be quite difficult to access with standard open and microscopic techniques. Trost et al[9] described the first bilateral intracorporeal robot-assisted microsurgical vasovasostomy in a patient who had bilateral iatrogenic vasal obstruction due to a prior bilateral inguinal hernia repair. The authors successfully manage to perform a minimally invasive bilateral intracorporeal anastomosis.

Other andrological surgeries can also be accomplished with robotics, including robotic-assisted microsurgical subinguinal varicocelectomy and microsurgical testicular sperm extraction (TESE and micro-TESE). Concerning varicocelectomy, in this procedure the dilated veins are extracorporeally tied and ligated with robotic microinstruments through a subinguinal incision[10]. The use of the robotic platform allows microsurgeons to simultaneously use additional instruments, such as the micro-doppler probe with the fourth robotic arm in real-time during dissection of the veins with the other two hands. Concerning the use of robotics in micro-TESE (ROTESE), there is an increasing interest in this technique since the tri-view feature with the video link from the andrology lab microscope during the procedure is a tremendous advantage for the microsurgeon. In fact, the surgeon can see the tissue being evaluated real-time, and thus he can use this information to move to areas or tubules that appear more promising[11].

In conclusion, recent techniques are available, but larger prospective studies are needed. Meanwhile, careful patient and partner evaluation, intra-operative analysis of vasal fluid, and utilization of the operative microscope yields excellent technical and satisfactory reproductive outcomes.

References:

1. Yu H, Hevelone N, Lipsitz S et al. Use, costs and comparative effectiveness of robotic assisted laparoscopic and open urological surgery. J Urol 2012; 187: 1392-1398.
2. Fleming C. Robot-assisted vasovasostomy. Urol Clin North Am 2004; 31:769-772.
3. Gudeloglu A, Brahmbhatt J, Parekattil S. Robot-assisted microsurgery in male infertility and andrology. Urol Clin North Am 2014; 41:559-566.
4. Parekattil S, Atalah H, Cohen M. Video technique for human robot-assisted microsurgical vasovasostomy. J Endourol 2010; 24: 511-514.
5. Parekattil S, Gudeloglu A, Brahmbhatt J et al. Robotic assisted versus pure microsurgical vasectomy reversal: technique and prospective database control trial. J Reconstr Microsurg 2012; 28: 435-44.

6. Kavoussi P. Validation of robot-assisted vasectomy reversal. Asian J Androl 2015; 17:245-247.
7. Gudeloglu A, Brahmbhatt J, Parekattil S. Robotic microsurgery in male infertility and urology – taking robotics to the next level. Transl Androl Urol 2014; 3:102-112.
8. Patel A, Smith R. Vasectomy reversal: a clinical update. Asian J Androl 2016; 18: 365-371.
9. Trost L, Parekattil S, Wang J et al. Intracorporeal robot-assisted microsurgical vasovasostomy for the treatment of bilateral vasal obstruction occurring following bilateral inguinal hernia repairs with mesh placement. J Urol 2014; 191: 1120-1125.
10. Shu T, Taghechian S, Wang R. Initial experience with robotic-assisted varicocelectomy. Asian J Androl 2008; 10. 146-148.
11. Parekattil S, Gudeloglu A. Robotic assisted andrological surgery. Asian J Androl 2013; 15: 67-74.

IS PENILE REHABILITATION FOLLOWING RADICAL PROSTATECTOMY EVIDENCE BASED? SUPPORTING THE HYPOTHESIS

Run Wang, MD, FACS; Professor of Surgery (Urology)
Cecil M. Crigler, MD Chair in Urology; Director of Sexual Medicine Fellowship Program; University of Texas McGovern Medical School at Houston and MD Anderson Cancer Center Houston, TX 77030, USA

Prostate cancer is the leading solid-organ cancer in American men and one of the leading causes of cancer deaths. Radical Prostatectomy (RP) is commonly used therapy for localized prostate cancer[1]. Despite advancements in understanding the anatomy of the prostate and the neurovascular bundle with improved surgical techniques and improved technologies, the incidence of ED after RP is still very high and ranges from 26% to 100%[2]. Progress has been made in identifying the events that contribute to ED after RP. The neuropraxia and endothelial dysfunction resulting in ischemia, hypoxia, fibrosis and apoptosis are all believed to contribute to ED and penile atrophy[3]. There have been a number of studies that have attempted to prevent or reverse these deleterious changes. Regimented usage of erectile aids with phosphodiesterase type-5 (PDE5) inhibitors, vacuum erectile device, transurethral or intracavernosal administration of vasoactive agents aims to improve the circulation of oxygen and maintain the structure of the corporeal bodies. Despite the understanding of the mechanisms and well-established rationale for post-prostatectomy penile rehabilitation, there is still no consensus regarding effective rehabilitation programs. The majority of studies available assess the use of PDE5is in penile rehabilitation which have been proven to improve early assisted sexual function when compared to placebo. However, the use of PDE5is has not been proven to significantly improve in unassisted erections. These evidences have resulted in the recent guideline recommendation from the American Urological Association that men desire preservation of erectile function after treatment for prostate cancer by radical RP should be informed that early use of PDE5i post-treatment may not improve spontaneous, unassisted erectile function[4]. Clinical trials with other treatment modalities are limited to single center studies, small sample sizes, and no control with limited follow ups. However, significant amount of basic science studies and some clinical evidences did show benefits of penile rehabilitation in certain populations. It is believed that current rehabilitation may serve as penile tissue preservation[5]. Penile rehabilitation may also help to establish a healthy sexual relation for patients and their partners, regardless of whether there is complete restoration of spontaneous erectile function. Eventually, advancements in research and technology will create and refine management options for penile rehabilitation after prostate cancer treatment.

References:

1. Liu C, Lopez DS, Chen M, Wang R. Penile rehabilitation therapy following radical prostatectomy: a meta-analysis. J Sex Med 14:1496-1503, 2017.
2. Clavell-Hernandez J, Wang R. The controversy surrounding penile rehabilitation after radical prostatectomy. Transl Androl Urol 6: 2-11, 2017.

3. Wang R. Penile Rehabilitation after Radical Prostatectomy: Where do We stand and Where are We Going? J Sex Med 4 (4): 1085-97, 2007.
4. AUA Guideline: erectile dysfunction (to be published)
5. Wang R. Vaccum erectile device for rehabilitation after radical prostatectomy. J Sex Med 14: 184-186, 2017.

RECURRENT VARICOCELES: DIAGNOSIS AND TREATMENT

Selahittin Çayan, MD, FECSM; Professor of Urology
University of Mersin School of Medicine, Department of Urology, Mersin, Turkey

This presentation reviews how to manage an infertile men who had recurrent or persistent varicocele. Diagnosis and treatment of recurrent varicoceles will be also reviewed.

Varicocele is one of the most important causes of male infertility, and it may cause impaired semen parameters and higher rates of sperm DNA damage[1,2]. These abnormalities may lead to reduced natural pregnancy rates and increased need for use of assisted reproductive technology (ART)[1,2]. After treatment of primary varicocele, approximately 50% of men will have positive response to varicocelectomy, as defined 50% increase in total motile sperm count, and 40% of couples could achieve spontaneous pregnancy, leading to decreased need for ART[2-4]. The rest will not have positive response to varicocele treatment due to several reasons, including varicocele recurrence, hormonal and genetic abnormalities, molecular defects or unexplained reasons. In the multivariate analyses, there are no clinical findings or hormone levels to predict positive response to varicocele treatment.

The incidence of varicocele recurrence after surgical repair varies from 0% to 45%[5,6]. Recurrence is more common after repair of pediatric varicoceles. Therefore, an ideal method, which could provide the best result in sperm parameters with the lowest complication rate should be preferred to treat an infertile male with varicocele.

The role of redo varicocelectomy in infertile males with recurrent or persistent varicocele is controversial in the era of ART. However, up to 30% of ART treatments result in multifetal gestations, increasing the risk of lower birth weight and prematurity, as well as perinatal and maternal morbidity and mortality[7]. Therefore, natural conception is preferred, although surgery can lead to anesthesia related risks.

Pampiniform plexus consists of the internal spermatic veins, external spermatic vein, defferential vein and gubernacular vein. The left internal spermatic vein drains into the left renal vein at a straight angle, whereas the right internal spermatic vein drains directly into the inferior vena cava at an oblique angle. Therefore, left sided varicocele is more common than right sided. However, there are some variations, such as number of gonadal veins, localization of drainage and termination angle in some cases, that could explain higher incidence of bilateral varicoceles and also causes for varicocele recurrences after the surgery or intervention[8]. These variations were found more frequently on the left side (30%), as compared to right side (10%). In some cases (10%), the variations were present bilaterally. Venous reflux is likely to be induced via collateral pathways, whereas in adolescents congenital venous abnormalities (renospermatic bypass, Nutcracker phenomenon and valve abnormalities) are predominantly present[9]. In addition, obesity is another risk factor for varicocele recurrence. Increased body mass index in men with varicocele is associated with larger spermatic vein diameters when supine[10].

The most common cause of persistent or recurrent varicocele after surgical repair is through the internal spermatic veins[11,12]. Studies demonstrate that varicocele recurrences might be due to unligated small internal spermatic vein branches in two-third, and due to inability to ligate external cremasteric vessels, because one-third of all patients with varicocele had reflux into the extrafunicular veins (cremasteric, external pudendal, deferential)[13]. In our experience, anatomic causes of recurrences were

due to dilated external spermatic vein and unligated internal spermatic vein vessels in the majority of patients (56.3%), only unligated small internal spermatic vein branches in 37.9%, and only dilated external spermatic vein in 5.8% of the patients[11].

Physical examination may not be enough to diagnose recurrent varicoceles in subfertile men. Additional radiologic imaging such as Doppler ultrasound is necessary to confirm recurrent varicoceles[5,6-11].

Indications for treatment of recurrent varicoceles are no improvement in semen parameters and not achieving pregnancy after at least 6 months of initial varicocele in the presence of abnormal sperm parameters and presence of recurrent varicocele[5,6-11].

In the literature, very few studies have reported effects of different approaches (surgical: 5, embolization: 2, and sclerotherapy: 2) in treating recurrent or persistent varicoceles. However, up to date, only 4 studies consisting of surgical treatment have reported fertility outcomes after treatment of persistent or recurrent varicoceles in infertile men. Çayan et al reported that of the couples, 52.5% achieved to pregnancy in the redo microsurgical varicocelectomy group, and 39.2% had pregnancy in the control group (11). Spontaneous pregnancy rate was significantly higher in the microsurgical varicocelectomy group (39.7%) than in the control group (15.8%). Use of ART to achieve pregnancy was significantly lower in the microsurgical varicocelectomy group (60.3%) than in the control group (84.2%).

The best treatment modality for recurrent varicoceles in infertile men should include higher seminal improvement, spontaneous pregnancy rates and IVF success with lower complication rates such as recurrence or persistence, hydrocele formation and testicular atrophy. Even if we do our best to treat varicocele, only 35-50% of the patients will have a positive response to varicocele treatment, and 50% will not respond varicocele treatment due to recurrence, genetic abnormality, technical faily-ure. Therefore, the best method should have the lowest complication rates, and the ideal technique should aim ligation of all internal and external spermatic veins with preservation of spermatic arteries and lymphatics[14-15].

Microsurgical redo varicocele repair can be performed via inguinal or subinguinal approach. Although the subinguinal approach to microsurgical varicocelectomy obviates the need to open the aponeurosis of the external oblique, it is associated with a greater number of internal spermatic veins and arteries compared with the inguinal approach. Subinguinal redo microscopic varicocelectomy has disadvantages, needing more skills because of higher number of internal spermatic vein channels, higher risk for arterial injury due to smaller artery in diameter at the level of the external inguinal ring (16). In a study, conducted with 102 consecutive men who underwent subinguinal microsrgical varicocelectomy, a mean number of 12.9 internal spermatic veins, 0.9 external spermatic veins, 1.8 internal spermatic arteries and 2.9 lymphatics were identified per cord. In addition 88.2% of the internal spermatic arteries were surrounded by a dense complex of adherent veins, and the incidence of dilated external spermatic veins was 49.4%[16]. Microsurgical varicocelectomy technique has higher spontaneous pregnancy rates and lower postoperative recurrence and hydrocele formation than conventional varicocelectomy techniques in infertile men.

Microsurgical varicocele repair has significant potential not only to obviate the need for ART, but also to downstage the level of ART needed to bypass male factor infertility[3,17]. After varicocelectomy, intrauterin insemination (IUI) may be tried again for men who had not achieved pregnancy by natural intercourse. Varicocele repair may also increase IVF success in men who have had varicocele. Esteves and Agarwal reviewed 4 retrospective randomized studies, including 870 cycles with regard of varicocele presence and ICSI[17]. They concluded that performing varicocelectomy in patients with clinical varicocele prior to ICSI is associated with improved pregnancy outcomes. We published a paper, consisting of 217 infertile men with recurrent or persistent varicocele[11]. The patients were divided into two

groups: 120 men underwent redo microsurgical subinguinal varicocele repair, and 97 had observation only, as the control group. Of the couples, 63 (52.5%) achieved to pregnancy in the redo microsurgical varicocelectomy group, and 38 (39.2%) had pregnancy in the control group ($p<0.05$). Microsurgical subinguinal redo varicocele repair improves postoperative semen parameters, serum total testosterone level and spontaneous pregnancy rates, compared to the controls. It also decreases need for use and level of ART. Chen et al found significant predictive factors of successful redo varicocelectomy as lower FSH and peak retrograde flow on Doppler ultrasound, longer time to recurrent varicocele, preoperative larger testicular volume and a higher number of ligated veins during redo varicocelectomy[18].
In conclusion, indications for evaluation of recurrent varicoceles are no improvement in semen parameters, no pregnancy, persistent pain 6-12 months after initial treatment of primary varicocele. Persistent or recurrent varicoceles should be confirmed with color Doppler ultrasound. Most reasons for recurrence are unligated internal and dilated external spermatic veins in the majority of patients. Based on the anatomic variations of testicular veins, inguinal or subinguinal varicocelectomy should be preferred to prevent from duplicated veins and also to ligate external spermatic vein. Optical magnification should be used to decrease postoperative re-recurrence, arterial injury and occurence of hydrocele. Microsurgical redo varicocele repair may improve postoperative sperm parameters, serum total testosterone level and spontaneous pregnancy rates, compared to the controls. It also decreases need for use and level of ART.

References:

1. Samplaski M, Lo KC, Grober ED, Zini A. Varicocelectomy to upgrade semen quality to allow couples to use less invasive forms of assisted reproductive technology. Fertil Steril. 2017;108:1-4.
2. Kohn TP, Phil M, Kohn JR, Pastuszak AW. Varicocelectomy before assisted reproductive technology: are outcomes improved? Fertil Steril. 2017;108:385-91.
3. Çayan S, Erdemir F, Ozbey I, Turek PJ, Kadioglu A, Tellaloglu S. Can varicocelectomy significantly change the way couples use assisted reproductive technologies? J Urol. 2002;167:1749-52.
4. Kirby EW, Wiener LE, Rajanahally S, Crowell K, Coward RM. Undergoing varicocele repair before assisted reproduction improves pregnancy rate and live birth rate in azoospermic and oligospermic men with a varicocele: a systematic review and meta-analysis. Fertil Steril. 2016;106:1338-43.
5. Çayan S, Shavakhabov S, Kadioglu A. Treatment of palpable varicocele in infertile men: a meta-analysis to define best technique. J Androl. 2009;30:33-40.
6. Rotker K, Sigman M. Recurrent varicocele. Asian J Androl. 2016;18:229-33.
7. Chiles KA, Schlegel PN: Role for male reconstruction in the era of assisted reproductive technology. Fertil Steril 2016;105:891-2.
8. Vanlangenhove P, Dhondt E, Maele GV, et al: Internal spermatic vein insufficiency in varicoceles: a different entity in adults and adolescents. AJR 2015;205:667-675.
9. Murray RR, Mitchell SE, Kadir S, Kaufman SL, Chang R, Kinnison ML, et al. Comparison of recurrent varicocele anatomy following surgery and percutaneous balloon occlusion. J Urol. 1986;135:286-9.
10. Najari BB; Katz MJ, Schulster ML, et al: Increased body mass index in men with varicocele is associated with larger spermatic vein diameters when supine. Urology 2016;89:40-44.
11. Çayan S, Akbay E: Fate of recurrent or persistent varicocele in the era of assisted reproductive technology: Microsurgical sub-inguinal redo varicocelectomy versus observation. Urology 2018; April, in press.
12. Tefekli A, Çayan S, Uluocak N, et al: Is internal spermatic venography necessary in determining recurrence varicocele after varicocele surgery. Eur Urol 2001; 40: 404-8.
13. Franco G, Iori F, de Dominicis C, Dal Forno S, Mander A, Laurenti C. Challenging the role of cremasteric reflux in the pathogenesis of varicocele using a new venographic approach. J Urol. 1999;161:117-21.
14. Çayan S, Lee D, Black LD, Reijo Pera RA, Turek PJ: Response to varicocelectomy in oligospermic men with and without defined genetic infertility. Urology 2001; 57: 530-5.
15. Çayan S, Shavakhabov S, Kadıo lu A. Treatment of palpable varicocele in infertile men: A meta-analysis to define the best technique. J Androl 2009; 30(1): 33-40.
16. Lv KL, Zhuang JT, Zhao L, et al: Varicocele anatomy during subinguinal microsurgical varicocelectomy in Chinese men.

Andrologia 2015;47:1190-1195.
17. Esteves SC and Agarwal A: Varicocele and male infertility: current concepts and future perspectives. Asian J Androl 2016; 161:2.
18. Chen SS. Predictive factors of successful redo varicocelectomy in infertile patients with recurrent varicocele. Andrologia. 2014;46:738-43.

MALE INFERTILITY. TREATMENT CONTROVERSIES
"PREDICTIVE FACTORS OF SUCCESSFUL TREATMENT FOR TESTICULAR DYSFUNCTION IN PATIENTS WITH HYPOGONADOTROPIC HYPOGONADISM"

Thorsten Diemer, ESAU Board Member
Dept. of Urology, Pediatric Urology and Andrology, UKGM GmbH, Campus Giessen, Justus-Liebig-University Giessen, Germany

Hypogonadotropic hypogonadism in males represents a more infrequent cause of testicular dysfunction typified by hypogonadism/testosterone deficiency and male infertility. This secondary hypogonadism results from absent or inefficient secretion of LH and FSH from the pituitary gland without a primary testicular pathology resulting in inefficient stimulation of Leydig cells and spermatogenesis.
Hypogonadotropic hypogonadism can be congenital or acquired:

- Congenital causes:
  – Isolated hypogonadotropic hypogonadism
  – Kallmann´s syndrome
  – Prader-Willi syndrome
  – Pasqualini syndrome
- Aquired causes:
  – Tumours
  – Diabetes/Obesity
  – Hyperprolatinemia
  – Drugs, Surgery
  – Injury
  – Hypothalamic-pituitary irradiation

Congenital cause are rare with Kallmann´s syndrome (associated with anosmia) representing the classical situation of hypogonadotropic hypogonadism. Patients suffer from a genetic defect (e.g. KAL-1) affecting migration of hypothalamic neurons in embryonic development with subsequent inefficient GnRH stimulation of the pituitary gland. To date more than 25 genetic defects have been linked to this syndrome. Patients usually indicate an undisturbed development to a male phenotype but pubertal development is abnormal. These mostly young men are undervirilized, indicate strikingly low testosterone levels and are infertile as indicated by azoospermia. Acquired causes after puberty do not affect the male phenotype, however, affected patients suffer from hypogonadism-related symptoms and often are infertile due to severe disturbances in spermatogenesis. The pathology is more variable and complex depending on the onset and duration of hypogonadism. Other hormonal systems can be affected particularly in cases where trauma of surgery has resulted in major lesions of the pituitary gland. Disturbances in the hormonal axis of the thyroid gland and the adrenals requires a broad endocrine evaluation and multidisciplinary treatment.
Hypogonadism with testosterone deficiency is the apparent symptom of patients with hypogonadotropic hypogonadism: Fatigue, sexual dysfunction and cognitive symptoms can be the clinical hall-

marks of the condition. If testosterone deficiency is the primary problem testosterone therapy can be successfully administered according to guideline recommendations. Therapy with testosterone is not different from therapy regimens in male hypogonadism due to other cause, and patients usually respond promptly to the therapy.

Hypogonadotropic hypogonadism due to congenital causes requires a different strategy since patients mostly need induction of puberty at first. Stimulation of testicular functions (endocrine and exocrine compartment) appears to respond to an initial induction with administration of hCG and FSH (recombinant) or hMG (induction of spermatogenesis and stimulation of Leydig cells), followed by testosterone therapy that sustains normal testosterone levels responsible for pubertal development, penile growth and virilization. Virilization is a quite important issue for patients with congenital hypogonadotropic hypogonadism at the onset of treatment after diagnosis while fertility is not the predominant problem. Testosterone therapy is halted when patients on testosterone therapy wish to father a child and stimulation with GnRH or gonadotropins (hCG and FSH) is commenced. Most patients respond to the stimulation indicated by the recurrence of spermatogenesis and fertility can be restored in a significant amount of cases with occurrence of spontaneous pregnancies. However, some patients do not respond to this stimulation and remain azoospermic. Eventually TESE and M-TESE have to be explored to retrieve spermatozoa from testicular tissue for ART.

Success of hormonal stimulation cannot be predicted easily. However, observational studies have revealed that men with cryptorchidism and small testes below 4ml/side might have a poor prognosis concerning recovery of spermatogenesis and restauration of fertility. Systematic studies are missing due to the low number of patients but standard protocols for the treatment are available.

The situation is similar for patients with acquired hypogonadotropic hypogonadism due to their individual causes for the loss of hypothalamic-pituitary function. Early onset of treatment appears to be a positive predictor for recovery of testicular function but individual differences might be enormous.

Pulsatile GnRH treatment is feasible in patients with hypogonadotropic hypogonadism but costs and complex delivery systems are apparent disadvantages. Intramuscular and subcutaneous injections of hCG (1500 I.E/week) and recombinant FSH 3x150 I.E./week) represent more suitable modes of therapy. Restauration of fertility with recurrence of spermatozoa in the ejaculate might require treatment for more than 1-2 years.

SPERM RECOVERY FROM MEN WITH CHROMOSOMAL ABNORMALITIES OR Y-CHROMOSOME MICRODELETIONS

Zsolt Kopa, ESAU Board Member
Andrology Center - Semmelweis University, Dept. of Urology – Budapest, Hungary

Infertility affects 16% of couples in developed western countries, in approximately 50% of the cases male factor is also involved. As recently reported 1 in 13 men of reproductive age requests medical care to achieve a pregnancy or to have a child.

Azoospermia accounts for 15% of male infertility cases: obstructive and non-obstructive azoospermia occur 15-40% vs. 60-85% in the literature. Genetic factors can be found in approximately one-third of azoospermia cases (29%), but in idiopathic azoospermia more, until now unknown genetic factors can be suspected.

Azoospermia of a genetic origin shows a wide array of genetic disorders. Chromosomal abnormalities can affect sex chromosome or autosomes. Sex chromosomal abnormalities can be divided into nu-

merical or structural changes. Autosomal abnormalities are mostly Robertsonian or reciprocal translocations, inversions and others. Gene mutations can occur on the X or the Y chromosome. X linked disorders affect the hypothalamus-pituitary-testis axis, e.g. Kallman syndrome, DAX1 gene failure or androgen insensitivity syndrome. The Y chromosome-linked mutations manifest in Yq11 microdeletions, SRY gene translocations or mutations. Autosomal gene mutations can cause CFTR mutations, monogenic disorders (metabolic diseases), or gonadotropin receptor defects.

The most frequent genetic alteration in male infertility is the Klinefelter syndrome (KS). The origin of this alteration is a meiotic non-disjunction during parental gametogenesis. The typical phenomenon is 47,XXY or mosaicism (46,XY/47,XXY). Patients have usually small, but firm testicles and are characterised from normal virilisation to androgen deficiency symptoms. Long arms and long legs are resulted due to failed epiphysis closure. Leydig cell dysfunction is most common with normal but in most of the cases decreased serum testosterone levels. Germ cell presence and spermatogenesis are variable in mosaicism. FISH examination finds an increased frequency of sex chromosomal abnormalities and an increased incidence of autosomal aneuploidy which should raise concerns regarding assisted reproduction (ICSI). Regarding of the 2018 EAU Guidelines on male infertility, there is a growing evidence that testicular sperm extraction (TESE or microdissection TESE) yields higher sperm recovery rates when done at a younger age. Surgical sperm retrieval in prepubertal or peripubertal KS boys should be considered experimental within a research protocol. Sperm FISH analysis provides a more accurate risk estimation for the offsprings, preimplantation genetic diagnostics (PGD) is recently questionable and a debated issue. Rohayem et al. reported in 2015 higher sperm retrieval rate (SRR) in adolescent and young adult age. SRR was independent of testicular volume, FSH, Inhibin B and AMH levels. 54% SRR was found in adolescent patients when compensated Leydig cell function where LH was less than 17,5 U/l., and TT exceeded 7,5 nmol/l. Over 17,5 U/l. LH and less than 7,5 nmol/l. testosterone SRR was found only 9%. Pretreatment testosterone replacement therapy had no negative effect on the outcome when stopped before 6 months prior to surgery. Regarding a recent systematic review and meta-analysis from Corona et al. SRR per TESE cycle is 44% in KS patients. Similar results were found comparing the outcome of conventional and microdissection TESE. Age, testis volume hormone levels did not have any influence on SRR. Live birth rate was reported as 43%.

Structural sex chromosomal abnormalities affecting the Y chromosome can result in 46,XX male syndrome. 90% of the cases are SRY gene positive, where the SRY gene is translocated to the X chromosomes or different autosomes. SRY-negative 46,XX male cases can be explained by the effect of DAX1, SOX3, SOX9, RSPO1 activities. In 46,XX male cases TESE or mTESE are not indicated because of the lack of spermatogenesis. A special attention should be put on the rare transplantional chimaera cases. Most frequent autosomal abnormalities are reciprocal and Robertsonian translocations. These genetic abnormalities are frequently linked to recurrent miscarriages. ICSI or TESE+ICSI can be performed using PGD or amniocentesis.

From several gene mutations, Kallman syndrome (Kalig-1 gene mutation) and androgen insensitivity syndrome should be highlighted. Kallman syndrome as a form of hypogonadotropic hypogonadism can effectively be treated with hormonal therapy, in most of the cases spermatogenesis can be induced. In persistent azoospermia despite long periods of hormonal treatment requires TESE or mTESE, where high SRR data are reported. In a mild androgen insensitivity syndrome azoospermic patient, the first successful TESE+ICSI was published in 2012.

Regarding autosomal gene mutations, Kartagener syndrome has a special fertility impact with necrozoospermia. TESE+ICSI was reported with higher pregnancy rate compared to ICSI using ejaculated sperms. The male Turner syndrome (Noonan syndrome) is most frequently characterized with undescended testicles and azoospermia. Good chance of SRR is documented undergoing microdissection

TESE in these cases.
Cystic fibrosis transmembrane conductance regulator gene mutation influences the formation of ejaculatory duct, vas deferens and two third of the epididymis resulting obstructive azoospermia. Microsurgical epididymal sperm aspiration (MESA) results in mature sperms for ICSI and is linked to higher live birth rates.
Y chromosome microdeletions can occur as partial or complete and affect either AZFa or AZFb or AZFc region, but can also be present in combined forms. Gene-specific and en-block deletions can occur. Reviewing the literature in the case of AZFa and AZFb microdeletions no spermatozoa can be found using several sperm retrieval techniques, so in these cases, TESE or mTESE are not recommended. In isolated AZFc microdeletions ejaculated sperms can also (rarely) found, mTESE presents more than 50% SRR. In a recent publication, mTESE was shown superior to conventional TESE technique.
Having the above-mentioned data a correct management of azoospermic patients can be performed. Indication for karyotyping are <10 M/ml. sperm concentration or recurrent miscarriages, congenital disorders and mental diseases. Y chromosome microdeletions are recommended to test below 5 M/ml. sperm concentration, but most of the cases can be found when sperm cc. is less than 1 M/ml. Correctly indicated sperm retrieval and microsurgical techniques allow the most appropriate treatment and counselling of severe male infertility patients.

RESUMOS DE COMUNICAÇÕES LIVRES

XVI CONGRESSO NACIONAL DA SOCIEDADE PORTUGUESA DE ANDROLOGIA, MEDICINA SEXUAL E REPRODUÇÃO

ABSTRACTS

ESAU OPORTO MEETING
JOINT MEETING: ANDROLOGY IN EUROPE 2018

COMUNICAÇÕES ORAIS

SESSÃO DE COMUNICAÇÕES ORAIS 1

Sexta-feira / 01 de junho de 2018 – 14:30-15:30h

Júri: Fortunato Barros e Alfredo Soares

CO 01

ALTERAÇÕES DE REDES CEREBRAIS FUNCIONAIS EM PACIENTES COM DISFUNÇÃO ERÉCTIL PSICOGÉNICA: UM ESTUDO DE RESSONÂNCIA MAGNÉTICA FUNCIONAL

Hugo Antunes[1]; Francisco Rolo[1]; Luís Sousa[1]; Edgar Silva[1]; Nicoletta Cera[2]; Joana Carvalho[2]; Ana Quinta-Gomes[2]; Raquel Pereira[2]; Cátia Oliveira[2]; João Castelhano[3,4]; Erick Janssen[4,5]; Arnaldo Figueiredo[1]; Miguel Castelo Branco[3,4]; Pedro Nobre[2]

[1]Serviço de Urologia e Transplantação Renal, Centro Hospitalar e Universitário de Coimbra, Portugal; [2]Faculdade de Psicologia e Ciências da Educação, Universidade do Porto, Portugal; [3]ICNAS - Instituto de Ciências Nucleares Aplicadas à Saúde, Coimbra, Portugal; [4]IBILI – Instituto de Imagem Biomédica, Faculdade de Medicina da Universidade de Coimbra, Portugal; [5]Institute for Family and Sexuality Studies, Department of Neurosciences, University of Leuven, Leuven, Belgium; [6]The Kinsey Institute for Research in Sex, Gender, and Reproduction, Indiana University, Bloomington, IN, USA

Introdução e objetivos: Os mecanismos cerebrais subjacentes ao processamento cognitivo-afetivo na disfunção eréctil (DE) são quase desconhecidos. O nosso estudo tem como objetivo comparar redes cerebrais funcionais envolvidas em diferentes funções emocionais e cognitivas em homens com DE psicogénica e homens saudáveis (HC).

Material e métodos: Nove doentes com DE e 13 controlos saudáveis foram avaliados durante a apresentação de clipes de vídeo sexuais e neutros. Os dados de ressonância magnética funcional (fMRI) foram adquiridos usando um scanner 3T. Avaliou-se a tumescência peniana (PT). Após pré-processamento e normalização de Talairach, a análise de componentes independentes espaciais (ICA) foi usada para decompor a série de fMRI num conjunto de padrões espaço-temporais independentes. Examinamos as redes visual somatomotora, controle frontoparietal (FPN), saliência (SN) e de atenção dorsal.

Resultados: Entre as redes incluídas, FPN e SN apresentaram diferenças significativas entre os grupos. A FPN é composta pelos córtex pré-frontal dorsolateral (dlPFC), cingulado anterior dorsal (dACC) e lobos parietais bilaterais superiores (SPL). SN é composto por lobo da ínsula bilateral e dACC. Os doentes com DE apresentaram níveis mais baixos de conectividade no dlPFC esquerdo e SPL esquerdo ($p < 0,05$) para FPN. Para o SN, os pacientes com DE apresentaram alto nível de conectividade no dACC ($p<0,05$).

Conclusão: Os efeitos encontrados na FPN, uma plataforma de controle flexível em diferentes sistemas neurais, são comuns a diversas doenças mentais. As diferenças encontradas no ACC da SN mostram o efeito negativo experimentado por pacientes com ED durante a estimulação sexual visual.

CO 02

DISFUNÇÃO SEXUAL EM DOENTES COM CIRURGIA RADICAL ONCOLÓGICA DO RECTO

Alberto Silva[2]; David Aparício[1]; Carlos Leichsenring[1]; António Gomes[1]; Augusto Pepe Cardoso[2]; Francisco Carrasquinho[2]; Vasco Geraldes[1]; Vítor Nunes[1]
[1]Serviço de Cirurgia, Hospital Professor Doutor Fernando da Fonseca; [2]Serviço de Urologia, Hospital Professor Doutor Fernando da Fonseca

Objetivos/Introdução: O tratamento da neoplasia do recto inclui a excisão completa do mesorecto associada ou não a quimioradioterapia(QRT). Esta abordagem associa-se a complicações genito-urinárias(11-76%) com importante repercussão na qualidade de vida dos doentes.

Material e métodos: Estudo retrospectivo (1/1/2015 - 31/7/2017) Inclusão se: sexo masculino, >18 e 75 ≤anos, cirurgia eletiva radical oncológica do recto (CEROR) Exclusão se: cirurgia radical pélvica prévia; disfunção sexual (DS) grave prévia; algaliação crónica *Outcome*: DS -Variáveis: localização do tumor(recto médio--baixo(RMB) Vs Recto alto);tipo de cirurgia(excisão total de mesorecto (TME); excisão parcial de mesorecto (PME);amputação abdomino-perineal (AAP); Via de abordagem; complicações; estoma; critérios anatomopatológicos; QRT. Aplicação de questionários: IIEF;BIPQ e IPQ após diagnóstico, após CEROR e após restabelecimento do trânsito intestinal Significância estatística: $p<0.05$

Resultados: N=42 (participação de 55%). 70% tumores RMB (p=0.26). 30% PME; 48% TME; 22% AAP (p=0.32). 22% por VL (p=0.18). 78% com estoma após CEROR (p=0.18). 96% mesorecto integro ou quase íntegro. 91% de ressecções R0. 43% com T>2 (p=0.73). 21% necessidade de re-intervenção cirúrgica (p=0.39). 49% foram submetidos a QRT neoadjuvante (p=0.38). 65% dos doentes apresentam DS: 57% se ausência de estoma, 70% nos com estoma; 75% se tumor do RMB e 50% se recto alto.

Discussão/Conclusão: A maioria dos doentes que são submetidos a CEROR apresentam DS. Não foi observado relação entre DS e localização tumoral, tipo de cirurgia, via de abordagem, T, re-intervenção cirúrgica e QRT neoadjuvante

CO 03

NÍVEIS DE TESTOSTERONA EM HOMENS COM DM TIPO 1 – QUAL O PAPEL DA VITAMINA D?

Nelson Cunha[1]; Leonor Gomes[1,2]; Diana Oliveira[1,2]; Adriana Lages[1,2]; Mara Ventura[1,2]; Lúcia Fadiga[1]; Diana Catarino[1]; Diana Silva[1]; Joana Guiomar[1]; Francisco Carrilho[1]
[1]Serviço de Endocrinologia, Diabetes e Metabolismo, Centro Hospitalar e Universitário de Coimbra (CHUC-EPE); [2]Faculdade de Medicina da Universidade de Coimbra

Introdução: Níveis insuficientes de vitamina D têm sido associados a várias patologias cardiovasculares e inflamatórias, existindo também alguns trabalhos que a relacionam com baixos níveis de testosterona. Sabe-se igualmente que os doentes com Diabetes mellitus (DM) têm maior prevalência de testosterona plasmática baixa, condição com maior risco cardiovascular.

Objetivo: Avaliar a prevalência de deficiência de vitamina D e de deficiência de testosterona plasmática num grupo de homens com DM tipo 1.

Métodos: Realizou-se um estudo observacional transversal que incluiu 26 homens com DM tipo 1, com idades entre 25 e 65 anos. Os dados foram obtidos através dos registos clínicos. Os parâmetros analíticos avaliados foram: 25-hidroxivitaminaD [25(OH)D], testosterona total (TT), testosterona livre (TL), hemoglobina glicada (A1C), perfil lipídico e razão albuminúria/creatininúria (RAC). Foram considerados níveis baixos de 25(OH)D<30ng/mL, de TT<3,0 ng/mL e de TL < 15pg/mL.

Resultados: A idade média foi de 40,0 ± 10,9 anos, com uma duração média de DM de 18,9 ± 11,9 anos. 54% apresentava IMC ≥25, 23,1% (n=6) TT baixa, 26,9% (n=7) TL baixa e 53,8% (n=14) níveis baixos de vitamina D. Os doen-

tes com A1C≥7% apresentaram TT mais baixa (3,73±1,14 vs 5,55±1,48; p=0,002), mas a diferença na TL e 25(OH)D não foram significativas, tendo-se verificado o mesmo nos doentes com IMC≥25kg/m2 (TT=3,61 vs 5,08; p=0,009). Os doentes com TL baixa apresentaram 25(OH)D mais baixa (23,3±9,6 vs 31,5±7,8; p=0,035), mas não se verificaram diferenças nos parâmetros avaliados entre os doentes com níveis baixos ou normais de 25(OH)D. No modelo de regressão linear, quando corrigido para a idade, IMC e duração DM, a associação entre os níveis de 25(OH)D e TL não foi estatisticamente significativa.

Conclusão: Nesta amostra cerca de 25% dos homens com DM tipo 1 apresentaram testosterona plasmática baixa e cerca 50% níveis baixos de vitamina D. Verificou-se que homens com pior controlo glicémico e IMC superior apresentaram TT mais baixa, podendo ser uma complicação destes efeitos metabólicos. Já a associação com os níveis baixos de vitamina D não teve significado estatístico. Assim, reforça-se a importância da manutenção do peso corporal normal bem como de um bom controlo glicémico para a prevenção desta complicação na DM tipo 1.

CO 04

PROGRAMA DE REABILITAÇÃO SEXUAL PÓS-PROSTATECTOMIA RADICAL: A IMPORTÂNCIA DE PROTOCOLOS DE ENFERMAGEM

Alexandre Gromicho; Pedro Costa; Raquel Rodrigues; Daniela Pereira; Débora Araújo; Jorge Dias; Rui Amorim; Paulo Espiridião; Luís Costa; Vítor Oliveira; Luís Xambre; Manuel Pereira; José Amaral; Luís Ferraz
Hospital Central do Funchal Centro Hospitalar Vila Nova de Gaia e Espinho

Introdução: A disfunção eréctil é uma das complicações mais frequentes pós-PR, condicionando perturbação significativa da qualidade de vida dos doentes. A administração precoce de fármacos para promover a reabilitação sexual está associada a uma elevada taxa de abandono.

Objectivos: Avaliar os resultados de um programa de enfermagem de reabilitação sexual com injeção intracavernosa de alprostadilo (IIA) pós-PR.

Material e métodos: Referenciados 120 doentes para programa de reabilitação sexual entre 2008 e 2016. Na primeira consulta de enfermagem é explicado o processo de preparação e administração da IIA, bem como as possíveis complicações associadas ao tratamento e realizado um teste. Nas consultas seguintes é iniciado o programa de ensinos em que o enfermeiro recolhe informações acerca do teste anterior e avalia a destreza e autonomia do doente na preparação e administração do fármaco.

Resultados: Total de 120 doentes com idade média de 63,1 anos. A maioria dos doentes assegurava ser sexualmente ativa previamente à cirurgia.

O programa de ensinos de enfermagem foi aceite por 109 doentes e recusado por 11 doentes (9,2%). Dos 109 doentes que aceitaram o programa de ensinos 95 (87.2%) concluíram-no com sucesso. Foram observadas complicações em 10% dos doentes que experimentaram IIA, (sendo a ereção dolorosa o mais reportado), motivando recusa/desistência do programa de enfermagem em 42% dos doentes.

Discussão e conclusão: Através deste estudo concluiu-se que dos 120 doentes referenciados, 95 (79.2%) adquiriu autonomia para preparar e administrar a medicação no domicilio, sugerindo que um programa de reabilitação sexual coordenado entre médicos e enfermeiros permite atingir boas taxas de adesão terapêutica.

CO 05

BAIXA PRESCRIÇÃO DE INIBIDORES DA FOSFODIESTERASE 5 NO TRATAMENTO DA DISFUNÇÃO ERÉCTIL EM DOENTE REFERENCIADOS PELOS CUIDADOS DE SAÚDE PRIMÁRIOS EM PORTUGAL

Afonso Morgado[1,2]; Carlos Silva[1,3]
[1]Serviço de Urologia, Centro Hospitalar São João; [2]Departamento de Biomedicina, Faculdade de Medicina da Universidade do Porto; [3]Departamento de Cirurgia e Fisiologia, Faculdade de Medicina da Universidade do Porto

Introdução: A disfunção eréctil (DE) é uma patologia prevalente em Portugal. Um estudo recente mostrou que 26.0% dos portugueses com mais de 60 anos refere problemas de ereção. Contudo, apenas 15.5% dos médicos de família em Portugal pergunta ativamente aos utentes por disfunções sexuais e 58.0% prefere referenciar à consulta de especialidade do que tratar a disfunção sexual.
Objetivos: Avaliar como e porque são referenciados os doentes com DE pelos cuidados de saúde primários (CSP) à consulta de especialidade.
Material e métodos: Trezentos doentes consecutivos referenciados por DE pelos CSP foram avaliados após consentimento informado entre Janeiro de 2016 e Dezembro de 2018. Foi realizada uma história médica e sexual padronizada. Foram registados os tratamentos prévios para DE, nomeadamente principio ativo e dosagem, bem como fatores de risco cardiovasculares.
Resultados: Apenas 33.8% dos doentes tinha sido previamente medicado com um inibidor da fosfodiesterase 5 e nenhum com alprostadil sob qualquer via de administração. Apenas 37.5% tinha sido escrito um IPD5 na dosagem mais alta. Sildenafil e avanafil foram os IPD5 mais escritos com 28.6% dos doentes cada. Todos estes doentes foram referenciados por falência de tratamento. Dos restantes doentes não tratados apenas 7.3% apresentava 3 ou mais fatores de risco cardiovascular necessitando de prova de esforço prévia a início tratamento e 7.8% avaliação por Cardiologia de acordo com o consenso de Princeton. Adicionalmente, 13.9% apresentavam um diagnóstico exclusivo de ejaculação prematura.
Conclusões: Os doentes que sofrem de disfunção eréctil em Portugal não estão a receber tratamento médico suficiente pelos CSP o que é demonstrado pela baixa prescrição de IPD5 prévia á referenciação.

CO 06

DISFORIA DE GÉNERO NOS CUIDADOS CLÍNICOS ESPECIALIZADOS

Filipe Couto Gomes; Mariana Silva; Tomás Teodoro; Catarina Ferreira; Marco Gonçalves
Centro Hospitalar Psiquiátrico de Lisboa

Introdução: A Consulta de Sexologia Clínica do CHPL é uma das unidades públicas especializadas em disforia de género.
Objetivos: Pretendeu-se caracterizar o conjunto dos casos acompanhados.
Métodos: Selecionaram-se os casos com pelo menos um contacto entre 2014 e 2017. Recolheram-se dados sociodemográficos e clínicos nos processos informáticos, fazendo-se uma análise estatística simples.
Resultados: O n.º de novos casos em 2017 (53) foi bastante superior ao dos anos anteriores. Destaque-se o reduzido número de casos dos distritos de Leiria e Santarém e das regiões do Alentejo e do Algarve. Na faixa entre 15 e 29 anos encontravam-se 81,8% dos homens trans e 44,4% das mulheres trans. Relativamente à idade dos homens trans, encontra-se notória tendência decrescente desde 2014: estavam na faixa 15-29 67,6% dos homens trans em 2014, 71,9% em 2015 e 79,6% em 2016. Outros quadros psiquiátricos estavam registados para 51,4% em 2017, 48,8% em 2016, 54,0% em 2015 e 53,8% em 2014. A prevalência de patologias médicas vem diminuindo de 49% em 2014 para 24% em 2017, sendo as mais frequentes a asma (de 1 a 9 casos por ano), hipertensão arte-

rial (2-6), dislipidemia (3-5) e VIH (4-6).
Conclusões: Os casos de disforia de género têm-se tornado mais numerosos, e principalmente quanto aos homens trans, mais jovens. O reduzido número de casos relativamente a alguns distritos sugere dificuldades no acesso às equipas especializadas. A diferença na idade à primeira consulta sugere que as mulheres trans possam sofrer barreiras adicionais no acesso aos cuidados especializados. Outros diagnósticos psiquiátricos são frequentes.

CO 07

ANÁLISE CUSTO-BENEFÍCIO DO DOSEAMENTO DE TESTOSTERONA TOTAL VERSUS ESTUDO HORMONAL COMPLETO NA AVALIAÇÃO DA DISFUNÇÃO ERÉCTIL EM DOENTES REFERENCIADOS PELOS CUIDADOS DE SAÚDE PRIMÁRIOS: RESULTADOS PRELIMINARES

Afonso Morgado[1,2]; Carlos Silva[1,3]
[1]Serviço de Urologia, Centro Hospitalar São João; [2]Departamento de Biomedicina, Faculdade de Medicina da Universidade do Porto; [3]Departamento de Cirurgia e Fisiologia, Faculdade de Medicina da Universidade do Porto

Introdução: O hipogonadismo é uma co-morbilidade prevalente na disfunção eréctil (DE), pelo que está recomendado o doseamento da testosterona total (TT) para exclusão de hipogonadismo em doentes com DE. Apenas em casos de valor baixo de TT está recomendado o doseamento de LH, SHBG e albumina. Contudo, a necessidade de colheita de sangue adicional bem como a necessidade de consulta adicional pode tornar esta abordagem sequencial dispendiosa.
Objetivos: Avaliar o custo-benefício do doseamento da TT versus avaliação hormonal completa inicial em doentes com referenciados por DE
Material e métodos: Cinquenta e sete doentes referenciados pelos CSP por DE foram submetidos a doseamento de TT para exclusão de hipogonadismo. Em caso de TT inferior a 345 ng/ml um estudo hormonal completo com TT, LH, SHBG e albumina foi subsequentemente realizado. Os custos foram calculados utilizando a tabelas de referência do Serviço Nacional de Saúde. Os custos desta abordagem sequencial foram comparados com o custo de um estudo hormonal completo inicial.
Resultados: A testosterona total foi inferior a 345 ng/mL em 33.3% (n = 19 em 57), tendo sido realizado posteriormente o estudo hormonal completo. Com esta abordagem, foi calculado uma poupança directa de 0,51 € por doente. No entanto, um terço dos doentes foi submetido a uma nova colheita de sangue e houve necessidade de uma nova consulta.
Conclusões: Estes resultados põem em causa as actuais recomendações de dosear apenas a TT em doentes com DE numa fase inicial, já que um terço dos doentes necessita de uma nova colheita de sangue e uma nova consulta, com custos indirectos associados como a perda de tempo e de produtividade.

CO 08

ABORDAGEM DA SEXUALIDADE NOS DOENTES ONCOLÓGICOS

Mafalda Cruz; Joana Brandão; João Casalta; Cláudia Sousa; Kayla Pereira; Domingos Roda; Gilberto Melo
Instituto Português de Oncologia de Coimbra

Introdução: Os distúrbios sexuais são extremamente comuns nos doentes oncológicos, sendo que 35-50% dos doentes terão disfunção sexual como consequência do cancro ou do seu tratamento. A problemática da sexualidade é ainda pouco abordada com o doente oncológico.
Objetivos: Determinação do impacto da doença oncológica a nível afetivo/sexual e da satisfação dos doentes quanto à informação fornecida. Avaliação da importância de consultas especializadas em oncossexologia.
Métodos: Estudo transversal que incluiu doentes admitidos num serviço de Radioterapia. Foram incluidos doentes em diversas fases do tratamento oncológico.

Resultados: Amostra de 104 doentes em que a maioria (60,6%) referiu que o tratamento oncológico teve um impacto negativo na sua vida sexual. Cerca de 30% dos doentes referiram estar insatisfeitos quanto à informação fornecida pelos profissionais de saúde sendo que apenas 5,7% dos doentes consideraram esta temática irrelevante. 66,4% afirmam que recorreriam a uma consulta de oncossexologia caso fossem referenciados.

Discussão: A doença oncológica tem impacto na sexualidade desde o seu diagnóstico. Uma parcela de doentes considera que não recebeu informação suficiente relativamente a esta temática. Os achados deste estudo estão em concordância com a literatura, indicando que a sexualidade deve ser abordada com o doente oncológico desde uma fase inicial do tratamento.

Conclusões: A sexualidade deve ser abordada com o doente oncológico desde o início da doença pelo que os profissionais de saúde deverão estar sensibilizados e preparados para esta temática. Os cuidados especializados de oncossexologia são necessários por constituírem uma via de redução do impacto oncológico na qualidade de vida do doente.

CO 09

EDSEXU: EPIDEMIOLOGIA DAS DISFUNÇÕES SEXUAIS EM UNIVERSITÁRIOS

Pedro Moreira; Bruno Jorge Pereira
Faculdade de Ciências da Saúde, Universidade da Beira Interior (FCS-UBI) Centro Hospitalar Cova da Beira, EPE (CHCB)

Introdução: No homem adulto as disfunções sexuais estão bem documentadas, mas nos mais jovens, aborda-se pouco esta questão. Mesmo neste estrato etário as disfunções sexuais não são incomuns e questões relacionadas com a função sexual e sua alteração também preocupam os novos.

Objetivo: Caracterizar a prevalência de disfunções sexuais em estudantes universitários portugueses do sexo masculino. Verificar possíveis diferenças entre estudantes de Medicina e de outros cursos.

Materiais e métodos: Elaborou-se um questionário e distribui-se por 9 instituições de ensino superior. Analisaram-se os resultados com recurso ao SPSS®.

Resultados: Obtiveram-se 634 questionários válidos. 34,7% dos inquiridos refere estar "insatisfeito"/"muito insatisfeito" com a sua função sexual. Os estudantes de Medicina apresentavam maior satisfação com a função sexual. 49,1% dos elementos consideravam que a entrada no ensino superior prejudicou a sua vida e/ou função sexual. 4,3% e 11,9% relatam algum grau de dificuldade em ter ou manter a ereção, respetivamente. Em pelo menos metade das relações sexuais 18,2% relatavam ejacular com muito pouco estímulo e 24,1% antes de querer. 2,4% refere um IELT inferior a 1 minuto, 6,3% entre 1 e 3 minutos, e 7,1% superior a 30 minutos, com uma incidência de ejaculação prematura de 8,7% e ejaculação retardada de 7,1%. Verificou-se, uma influência negativa do consumo de álcool na qualidade das ereções e um IELT superior para fumadores.

Conclusão: As disfunções sexuais não são incomuns entre os universitários portugueses, existindo muitos jovens escassamente satisfeitos com a sua função e/ou vida sexual. Constataram-se algumas diferenças entre os estudantes de Medicina comparativamente com outros cursos, principalmente no que concerne à qualidade da vida sexual, confiança na capacidade eréctil e satisfação sexual global.

SESSÃO DE COMUNICAÇÕES ORAIS 2

Domingo / 03 de junho de 2018 – 08:30-09:30h

Júri: António Campos e Francisco Martins

CO 10

SERÁ A COLHEITA DE GÂMETAS POR BIÓPSIA TESTICULAR ABERTA EFICAZ NOS DOENTES AZOOSPÉRMICOS COM SÍNDROME DE KLINEFELTER PURO?

Débora Araújo[1]; Daniela Pereira[1]; Raquel Rodrigues[1]; Alexandre Gromicho[2]; Pedro Costa[1], Jorge Dias[1]; Luís Ferraz[1]

[1]CHVN Gaia/Espinho; [2]Hospital Central do Funchal

Introdução: O síndrome de Klinefelter (SK) é a etiologia cromossómica mais frequente na infertilidade masculina; caracterizado pela presença de um cromossoma X extranumerário (47, XXY). O SK puro (SKP) corresponde a cerca de 80-90% dos casos. Antes da era da colheita de gâmetas por biópsia testicular aberta (TESE), estes doentes eram orientados para técnicas de reprodução com recurso a esperma de dador. Hoje, a taxa de sucesso da TESE nestes doentes ronda os 50%, similar a azoospermias não-obstrutivas de cariótipo normal.

Objetivos: Descrever a experiência do nosso centro na realização da TESE no SKP.

Material e métodos: Foi realizado retrospetivamente um levantamento de todos os doentes com SKP com diagnóstico de azoospermia submetidos a TESE no Centro Hospitalar de Vila Nova de Gaia/Espinho no período de 1998 a 2015.

Resultados: 52 doentes azoospérmicos com SK puro foram submetidos a TESE unilateral (testículo direito) sob bloqueio do cordão espermático. A colheita de espermatozóides foi bem-sucedida em 21 dos casos, permitindo alcançar uma taxa de sucesso de 40.3%, independentemente das alterações hormonais e da idade. Não foram identificadas complicações. A taxa de fertilização foi de 38%, com um total de oito nascimentos. Todos os bebés nascidos são saudáveis.

Discussão/Conclusão: A TESE alcançou boas taxas de sucesso de colheita de espermatozóides e de fertilização nos doentes com SKP no nosso centro, permitindo-nos oferecer a possibilidade de uma paternidade biológica a estes doentes ao invés de recorrer imediatamente a recurso de esperma de dador.

CO 11

VARICOCELECTOMIA NA INFERTILIDADE – SERÁ A IDADE UM FACTOR IMPORTANTE?

Jorge Correia; André Pinto; Miguel Ramos; Nuno Louro; Avelino Fraga

Centro Hospitalar do Porto

Introdução: A prevalência de varicocelo na população geral é de 15%, encontrando-se presente em 35% dos homens com infertilidade primária e 70-81% com infertilidade secundária. A sua correcção melhora os parâmetros do espermograma e as taxas de fecundação. Contudo, ainda é controverso se ela tem a mesma eficácia nos homens de maior idade.

Objetivos: O objectivo deste estudo foi avaliar a eficácia da varicocelectomia na melhoria das contagens do espermograma, e verificar se varia entre diferentes grupos de idade.

Material e métodos: Análise retrospectiva dos doentes submetidos a varicocelectomia por infertilidade entre os anos de 2011 e 2017.

Resultados: Neste período foram intervencionados 42 doentes, sendo a média de idades 33,3±5,1 anos.

De um modo global, verificou-se uma melhoria na concentração de espermatozoides ($p<0,001$), motilidade progressiva ($p=0,001$) e morfologia ($p=0,001$), apesar de o último apresentar um maior número de doentes sem qualquer alteração (n=20, 48%). Não houve diferenças quanto ao volume de esperma ($p=0,1$). Dividindo os doentes em 2 grupos, utilizando como cut-off a idade média (<33 vs ≥33 anos), não se verificaram diferenças em relação ao nú-

mero de doentes que apresentou melhoria no espermograma (p=0.582). Verificou-se, contudo, uma melhoria mais acentuada na concentração de espermatozoides no grupo mais novo (aumento de 203%, p=0,02 vs 94%, p=0,004), sendo este o único que apresentou melhoria na motilidade (p=0,001).

Conclusão: A varicocelectomia é uma técnica eficaz na melhoria das contagens do espermograma. Os indivíduos mais novos são os que mais beneficiam, devendo por isso ser instituída o mais precocemente possível.

CO 12

TRATAMENTO DA DISFUNÇÃO ERÉTIL VASCULOGÉNICA COM ONDAS DE CHOQUE EXTRACORPORAIS DE BAIXA INTENSIDADE: EFICÁCIA E SEGURANÇA

Christophe Leite Pinto; António Pedro Carvalho; Paulo Pinto Santos
Hospital Privado da Trofa – Serviço de Urologia Grupo Trofa Saúde

A disfunção erétil (DE) é uma condição psicossexual preponderante na saúde masculina. A terapia extracorporal com ondas de choque de baixa intensidade (LI-ESWT) tem sido investigada pela sua capacidade de estimular a neovascularização e reparação celular a nível cavernoso. Trata-se da primeira investigação clínica portuguesa que avalia a eficácia e segurança da LI-ESWT em homens com DE vasculogénica ligeira a severa e compara estes resultados com um grupo de doentes tratados com inibidores da fosfodiesterase-5 (iPDE-5).

Neste estudo, um grupo de doentes exposto a LI-ESWT e outro a iPDE-5 foram acompanhados durante 9 semanas. A função erétil foi avaliada no início, às 5 e 9 semanas após começar o tratamento. Foi inquirida a ocorrência de efeitos adversos. Obtiveram-se parâmetros hemodinâmicos penianos no início e às 9 semanas de seguimento.

Foram tratados 18 doentes com LI-ESWT, com idade média de 60,8 anos. Verificaram-se melhorias significativas da função erétil e dos parâmetros hemodinâmicos ao longo do tratamento. A má resposta à farmacoterapia, a gravidade severa da disfunção e a presença de fatores de risco cardiovascular não influenciaram a resposta terapêutica. Comparativamente aos 30 doentes tratados com iPDE-5, apesar da LI-ESWT provocar uma melhoria significativamente maior da função erétil, as taxas de resposta não diferiram. A ocorrência de efeitos adversos distinguiu as duas modalidades, ocorrendo dez vezes mais com iPDE-5.

Este estudo reforça um efeito benéfico da LI-ESWT sobre a função erétil de homens com DE vasculogénica, comprovado pela melhoria demonstrada dos parâmetros hemodinâmicos penianos. A curto-prazo, esta técnica mostrou-se segura e tolerável.

CO 13

O IMPACTO DO TRATAMENTO COM ONDAS DE CHOQUE DE BAIXA INTENSIDADE NA DISFUNÇÃO ERÉTIL SEGUNDO TEMPO DE EVOLUÇÃO DA DOENÇA

Pedro Simões de Oliveira; Tiago Ribeiro de Oliveira; Álvaro Nunes; Francisco Martins; Tomé Lopes
SCI-Centro de Urologia, Lisboa

Introdução: A Disfunção Erétil (DE) é uma doença frequente e nenhum tratamento disponível trata a patologia de base. As Ondas de Choque de Baixa Intensidade (OCBI) podem curar a DE.

Objetivos: Avaliar o impacto das OCBI na DE segundo o tempo de duração da doença.

Material e métodos: Foram estudados prospectivamente doentes submetidos a OCBI entre Junho de 2016 e Março de 2018. Foram divididos em dois grupos segundo tempo de duração da doença: £24 meses (grupo 1) e >24 meses (grupo 2). A função erétil foi avaliada com o IIEF-5 antes do tratamento e 6 semanas e 3 meses após. Foi realizado ecodoppler peniano antes do tratamento e 6 semanas após.

Resultados: 25 doentes foram incluídos. Quinze

doentes tinham DE arteriogénica, quatro arteriogénica e fuga venosa, três pós prostatectomia radical e três fuga venosa. No grupo 1 o IIEF-5 mediano pré OCBI era 15, 6 semanas após OCBI era 17 (p 0.008), 3 meses após OCBI era 17 (p 0.012). A Velocidade de Pico Sistólico (VPS) mediana pré OCBI era 27.0 cm/s, pós OCBI era 30.1 cm/s (p 0.017). No grupo 2 o IIEF-5 mediano pré OCBI era 12.5, 6 semanas após OCBI era 15.0 (p 0.008), 3 meses após OCBI era 18.5 (p 0.018). A VPS mediana pré OCBI era 28.5 cm/s, pós OCBI era 32.7 cm/s (p 0.016).

No grupo 1 a melhoria no IIEF-5 ás 6 semanas foi de 69.2% e no grupo 2 de 66.7% (p 1.00), aos 3 meses, a melhoria no grupo 1 foi de 61.5% e no grupo 2 de 83.3% (p 0.378).

No grupo 1 a melhoria na VPS foi de 84.6% e no grupo 2 de 83.3% (p 1.00).

Discussão/Conclusões: OCBI é uma terapia não invasiva apresentando bons resultados no tratamento da DE.

O tempo de duração da doença não parece influenciar significativamente os resultados deste tratamento.

CO 14

SÍNDROME DE KLINEFELTER E FERTILIDADE

João Carvalho; Belmiro Parada; Pedro Nunes; Hugo Antunes; Maria Freire; Luís Sousa; Eunice Matoso; Alexandra Estevinho; Ana Paula Sousa; Teresa Almeida Santos; Arnaldo Figueiredo

Serviço de Urologia e Transplantação Renal do Centro Hospitalar e Universitário;; Serviço de Medicina e Reprodução Humana dos do Centro Hospitalar e Universitário; Serviço de Citogenética do Centro Hospitalar e Universitário

Introdução: O síndrome de Klinefelter é a alteração cromossómica sexual mais frequente que faz com que se verifique uma progressiva deterioração testicular e infertilidade.

Objetivos: Avaliar os doentes com síndrome de Klinefelter e a respectiva fertilidade.

Métodos: Foi realizado um estudo retrospectivo observacional de 24 doentes com Síndrome de Klinefelter seguidos na nossa instituição desde 2013 por quadro de infertilidade. A análise estatística foi efectuada recorrendo ao SPSS Software 22, $p<0.05$.

Resultados: A idade na primeira consulta era de 34.04±5.2 anos e a idade da respectiva mulher era de 30.7±5.0 anos. 37.5% eram fumadores. As comorbilidades mais frequentes eram infecciosas (25%) e a presença de varicocelo (20.8%). Apenas se verificaram 2 casos de mosaicismo e uma microdelecção do cromossoma Y. Apenas 2 doentes não eram azoospérmicos. Foram realizadas biópsias testiculares em 41.7%: Sertoli cell only syndrome e hiperplasia de células de Leydig. Todos os doentes tinham hipogonadismo hipergonatrófico, com LH de 16.8±3.5 um/mL, FSH de 34.2±12.7 um/mL e testosterona total de 2.5± 1.9 ng/mL.

Nenhum casal adoptou, cinco recorreram a banco de esperma, sendo que apenas um teve descendência, dois tiveram filhos sem necessidade de técnicas de PMA (Procriação Medicamente Assistida), dois já tinham tido descendência doutras relações e sete estão a realizar tratamentos. Foi utlizada FIV em 77.8% e ICSI em 22.2%. Não se verificou relação estatisticamente significativa entre testosterona e espermograma e fertilidade.

Discussão: Os doentes com Síndrome de Klinefelter são essencialmente azoospérmicos, apresentam testosteronémia diminuída, sendo que alguns conseguem ter descendência sem necessidade de tratamentos de PMA.

VÍDEOS

Domingo / 03 de junho de 2018 – 08:30-09:30h

Júri: António Campos e Francisco Martins

V 01

TRATAMENTO DA DOENÇA DE LA PEYRONIE INCISÃO DA PLACA E ENXERTO AUTO-ADESIVO

A. Pepe Cardoso; Alberto Silva; António M.Pinheiro
Hospital Prof. Doutor Fernando Fonseca

Introdução: A Doença de La Peyronie (DP) é uma doença pouco frequente, de etiologia desconhecida, com uma prevalência de 0,4 a 9 % no homem adulto, sendo que 2/3 dos casos surgem na faixa etária dos 55 aos 60 anos, e mais frequente em doentes com disfunção erétil e diabetes.

A DP caracteriza-se pela presença de placas de fibrose no pénis, por vezes facilmente palpáveis, ereções dolorosas, uma curvatura peniana com encurtamento peniano e por vezes disfunção eréctil que levam a que as relações sexuais sejam difíceis ou mesmo impossíveis.

As técnicas de alongamento do pénis, indicadas nas curvaturas superiores a 60 graus, com incisão ou excisão parcial ou total da placa são realizados no lado côncavo do pênis e requerem, geralmente, o uso de um enxerto (exceto em corporotomias inferiores a 1 cm) e visam minimizar o encurtamento do pênis ou corrigir deformidades complexas.

O uso de enxertos de matriz selante de fibrinogénio e trombina humana (colagénio) revelaram excelentes resultados, permitindo também a redução do tempo de cirurgia (técnica autoadesiva sem sutura) e uma boa hemóstase.

Objectivo, material e método: Apresentação e discussão de caso clínico de homem com DP, com curvatura dorsal extrema (a rondar os 90º graus), que foi submetido a técnica cirúrgica de alongamento incisão de placa com enxerto autoadesivo – Tachosyl®.

Realização de filme com descrição dos passos cirúrgicos da técnica apresentada.

Conclusão: A correcta indicação é preponderante para obtenção de tratamento potencialmente eficaz, sendo no entanto uma técnica operador dependente.

Enxerto de TachoSil® demonstrou ser uma opção/alternativa fiável, com boa relação custo/eficácia, excelente hemóstase, redução do tempo de cirurgia (sem necessidade de sutra) e menor risco de infeção. Ressalvar que nunca se deve menosprezar que a taxa de satisfação dependente das expectativas criadas, onde a informação detalhada pré cirúrgica é a chave do processo.

V 02

RETALHO DE PREPÚCIO PEDICULADO E TUBULARIZADO EM ESTENOSE DA URETRA BULBOMEMBRANOSA

Pedro Simões de Oliveira; Tiago Ribeiro de Oliveira; João Felício; Afonso Castro; David Martinho; Francisco Martins; Tomé Lopes
Serviço de Urologia, CHLN-Hospital de Santa Maria, Lisboa

Introdução: As estenoses da uretra bulbomembranosa com um segmento curto podem ser abordadas com excisão e anastomose topo-a-topo, no entanto, segmentos estenóticos mais longos, com fibrose peri-uretral, requerem uretroplastia de substituição. Existem múltiplas técnicas disponíveis com recurso a enxertos ou retalhos, desenvolvidas em um ou dois tempos cirúrgicos e usando mucosa bucal ou pele como zonas dadoras. Os retalhos de prepúcio são uma opção válida na reconstrução destas estenoses com grandes defeitos.

Materiais e métodos: Os autores apresentam um caso de um homem de 59 anos, com um aperto da uretra bulbar iatrogénico, tratado com Uretrotomia Interna sob visão (UI) 15 anos antes. Recidiva do aperto tendo sido submetido a uretroplastia de substituição com enxerto cutâneo de pele escrotal. Nove anos depois, nova recidiva tendo sido tratado com colocação contígua de dois stents uretrais UroLumes.

Cinco anos mais tarde apresentou-se com quadro de retenção urinária aguda complicada de fleimão escrotal tendo colocado uma punção suprapúbica.
Na avaliação atual apresentou:
- Urofluxometria: Qmáx 1 mL/s.
- Uretrocistografia: estenose severa da uretra bulbomembranosa e presença de dois stents uretrais.
- RMN pélvica: Presença de dois stents uretrais metálicos, sem evidência de trajetos fistulosos.
Foi submetido a uretroplastia bulbomembranosa. Intraoperatóriamente identificação de extensa fibrose envolvendo a uretra bulbomembranosa, com retração e distorção anatómica associado a erosão do stent uretral e um segmento de 8 cm de uretra estenótica, fibrótica e não mobilizável. Procedeu-se a resseção de todo o tecido fibrótico conjuntamente com segmento uretral envolvido contendo os dois stents uretrais. Um retalho de prepúcio foi mobilizado e transposto e posteriormente tubularizado, realizando uma uretroplastia de substituição.
Seis semanas mais tarde a avaliação apresentou:
- Urofluxometria: Qmáx 28.8 mL/s.
- Uretrocistografia: uretra permeável sem evidência de fuga.
- Bom resultado cosmético.
Discussão/conclusão: A pele de prepúcio é fina, maleável, desprovida de pêlo, encontra-se em proximidade com a uretra e oferece comprimento suficiente de material para substituição de longos segmentos estenóticos da uretra. Embora possa ser afetada por líquen escleroso ou complicada pela formação de divertículos, os resultados funcionais são semelhantes aos de outras técnicas, tendo ainda a vantagem de permitir correções num único tempo cirúrgico.

V 03

TÉCNICA PALUV (*PERCUTANEOUS ASSISTED LAPAROSCOPIC UNILATERAL VARICOCELECTOMY*)

Artur Palmas; Nuno Domingues; Tiago Oliveira; João Felício
Hospital das Forças Armadas – Pólo Lisboa

Objetivo: Descrever uma técnica de varicocelectomia unilateral laparoscópica assistida por via percutânea, em regime de ambulatório.
Métodos: O paciente é colocado em decubito semi-lateral. É introduzido um trocar de 10mm ao nível do rebordo inferior da cicatriz umbilical, por mini-laparotomia.
É utilizado uma óptica de 0º, e através de visão direta, o segundo trocar de 5mm é colocado ao nível suprapúbico. Entre os trocars colocados anteriormente, na linha média, um dissecador Maryland de 3,5mm, de Mini-laparoscopia, é inserido percutaneamente, a fim de auxiliar na dissecção. Através do trocar suprapúbico, utilizamos uma tesoura monopolar, para abrir o peritoneu parietal pélvico. Depois usamos um dissector para isolar a veia espermática, sempre auxiliado pelo dissector Maryland de 3,5mm. A artéria e os vasos linfáticos são preservados. A veia é clampada com Hem-o-lock. O encerramento cutâneo faz-se por 3-0 Vicryl rapid®, e a aponevrose injetada com Bupivacaína 0,5%. O paciente sai do hospital 6 horas após o procedimento.
Resultados: O tempo operatório foi de 27min. Com a ajuda do dissector Maryland de 3,5mm, inserido percutaneamente, o isolamento da veia espermática é técnicamente fácil e seguro. O que também permite uma preservação da artéria e dos vasos linfáticos. O paciente sai do hospital 6 horas após o procedimento sem dor significativa (escala de dor facial abaixo de 4).
Conclusão: A técnica PALUV é segura e eficaz. Em pacientes obesos, representa uma opção fácil para visualizar a veia espermática e permitir a preservação da artéria. Sem dor pós-operató-

ria, menor tempo de recuperação para retornar à atividade normal e boa satisfação estética virtualmente sem cicatrizes.

V 04

TÉCNICA 2PLUV (2 *PORT LAPAROSCOPIC UNILATERAL VARICOCELECTOMY*)

Artur Palmas; Manuel Ferreira Coelho
Hospital da Cruz Vermelha Portuguesa

Objetivo: Descrever a segurança e eficácia da varicocelectomia unilateral laparoscópica, por meio de uma técnica de 2 portas, em ambulatório. **Métodos:** 7 pacientes com varicocelo unilateral sintomático. Todos os varicoceles foram do lado esquerdo, confirmados por ultrassonografia com Doppler. O paciente é colocado em decúbito semi-lateral. Um trocar de 10 mm é colocado através do umbigo, após a insuflação prévia por agulha de Veress. É utilizada uma ótica de 0º, e através de visão direta, o segundo trocar de 5mm é colocado ao nível suprapúbico. Utilizando o trocar de 5mm, primeiro usamos uma tesoura monopolar, para abrir o peritoneo parietal pélvico, seguido de um dissector para isolar a veia espermática, e por ultimo um dispositivo de clip de 5mm, para clampar a veia. A artéria foi preservada em 3 pacientes. O encerramento cutâneo, faz-se por um 3-0 Vicryl rapid, e a aponevrose é injetada com Bupivacaína 0,5%. Os pacientes saem do hospital 6 horas após o procedimento, com aplicação da escala de dor facial. **Resultados:** Todos os procedimentos foram realizados por laparoscopia, sem conversões, portas adicionais ou complicações intraoperatórias. O tempo operatório médio foi de 36min (intervalo 18-50). Nenhuma recorrência / persistência ou hidrocele foram registrados. Todos os pacientes tiveram alta do hospital 6 horas após o procedimento com a escala de dor facial abaixo de 4. **Conclusão:** A técnica do 2PLUV é segura e eficaz, sem dor pós-operatória, menor tempo de recuperação para retornar à atividade normal e melhor satisfação estética virtualmente sem cicatrizes.

POSTERS

P 01

DOENÇA DE LA PEYRONIE – TÉCNICA CIRÚRGICA COM ENXERTO AUTOADESIVO APRESENTAÇÃO DA TÉCNICA E RESULTADOS PRELIMINARES

Alberto Silva; Ana Cebola; A. Pepe Cardoso
Hospital Prof. Doutor Fernando Fonseca E.P.E.

Introdução: A doença de La Peyronie (DP) é uma doença pouco frequente, de etiologia desconhecida, com uma prevalência de 0,4 a 9 % no homem adulto, sendo que 2/3 dos casos surgem na faixa etária dos 55 aos 60 anos, e mais frequente em doentes com disfunção erétil e diabetes.

A DP caracteriza-se pela presença de placas de fibrose no pénis, por vezes facilmente palpáveis, ereções dolorosas, uma curvatura peniana com encurtamento peniano e por vezes disfunção eréctil que levam a que as relações sexuais sejam difíceis ou mesmo impossíveis

As técnicas de alongamento do pénis, indicadas nas curvaturas superiores a 60o, com incisão ou excisão parcial ou total da placa são realizados no lado côncavo do pênis e requerem, geralmente, o uso de um enxerto (exceto em corporotomias inferiores a 1 cm) e visam minimizar o encurtamento do pênis ou corrigir deformidades complexas.

O uso de enxertos de matriz selante de fibrinogénio e trombina humana (colagénio) revelaram excelentes resultados, permitindo também a redução do tempo de cirurgia (técnica autoadesiva sem sutura) e uma boa hemóstase.

Objectivo: Apresentação e discussão de resultado de série de 7 doentes com DP que foi submetido a técnica cirúrgica de alongamento (incisão/excisão de placa) com enxerto autoadesivo.

Material e métodos: Estudo retrospetivo em que a amostra de doentes foi submetida a cirurgia de alongamento peniano com enxerto autoadesivo. Doentes encontravam-se em consulta de Urolo-

gia no Hospital Prof. Dr. Fernando Fonseca (HFF) e na Clínica de Stº António (CLISA – LUSÍADAS) por DP – entre o período de 01 Junho de 2017 a 30 de Março de 2018. O programa de monitorização pós-cirúrgico durou 1 e 3 meses. A população da amostra é constituída por homens, com idades entre 40 e 70 anos, tendo sido consultado o processo clínico (arquivo informático). A população selecionada pertence à área de influência do HFF e da CLISA – LUSÍADAS.

A função sexual foi avaliada através de um questionário validado, Índice Internacional de Função Eréctil (IIFE-5) adaptado e validado para população portuguesa e a realização de Ecodoppler Peniano.

Descrição de técnica cirúrgica ao longo do procedimento de alongamento peniano com enxerto autoadesivo (Tachosyl®) com Incisão de placa VS Excisão de placa.

Estudo retrospetivo apresentou os seguintes critérios de inclusão (Tabela 1).

Tabela 1 **Critérios de Inclusão**

- Estabilidade da doença/curvatura >12M
- Curvatura > 60 º
- IIFE-5 > 25
- Ecodoppler Peniano (Fase Rigidez) valores normais (PSV >30 cm/sec, EDV< 10 cm/sec , IR > 0,7

PSV -pico de velocidade sitólica, EDV – velocidade diastólica final , IR – Índice de Resistência ; IIEF- 5 , Índice Internacional de Função Eréctil – 5

Resultados: Descrição dos passos cirúrgicos de dois doentes , representativo das duas técnicas usadas, na cirurgia de alongamento peniano com enxerto autoadesivo.

Quadro sumário (Tabela 2) para caracterização da amostra, indicação da técnica, e resultado do respetivo acompanhamento pós cirúrgico.

Conclusão: A correcta indicação (se doença estável, sem ED e curvatura impeditiva para coito) são factores preponderantes para obtenção de tratamento potencialmente eficaz independente da técnica cirúrgica (Incisão/Excisão total ou parcial da placa fibrótica). É uma técnica operador dependente.

Enxerto de TachoSil® demonstrou ser uma opção/alternativa fiável, com boa relação custo/eficácia, excelente hemóstase, redução do tempo de cirurgia (sem necessidade de sutra) e menor risco de infeção. Ressalvar que nunca se deve menosprezar que a taxa de satisfação dependente das expectativas criadas, onde a informação detalhada pré cirúrgica é a chave do processo.

São necessários ainda mais estudos retrospectivos e prospectivos.

P 02

CORPOROPLASTIA COM ENXERTO DE TACHOSIL® NA CORRECÇÃO DA DOENÇA DE PEYRONIE: EXPERIÊNCIA INICIAL DE UM CENTRO

Francisco Fernandes; Pedro Baltazar; João Pina; Jorge Morales; Fernando Calais; Luís Campos Pinheiro
Centro Hospitalar de Lisboa Central

Introdução: A doença de Peyronie é responsável por deformação peniana no adulto impedindo por vezes o acto sexual. A correcção cirúrgica com aplicação de enxertos é a norma nos doentes com curvaturas complexas, superiores a 60º ou em pénis de pequenas dimensões.

Objectivos: Descrever a experiência de um centro na correcção de doença de Peyronie com utilização de enxerto de TachoSil®. Avaliar as complicações e resultados cirúrgicos.

Métodos: Análise retrospectiva de 4 doentes submetidos a Corporoplastia com utilização de enxerto de Tachosil®. Foram avaliados nos doentes os seguintes dados clínicos: capacidade eréctil, alteração da sensibilidade peniana, comprimento peniano, satisfação do doente e existência de curvatura residual. Antes da cirurgia foi efectuado doppler peniano com prova vasoactiva a todos os doentes.

Resultados: A nossa revisão incluía 4 doentes com média de idades de 60,3 anos [56-63]. A cirurgia foi efectuada pelo facto de os doentes apresentarem curvaturas dorsais proeminentes, com uma média de 80º [60-90]. O tempo cirúr-

gico médio foi de 80mins. Após a cirurgia não ocorreu alteração significativa do comprimento nem da sensibilidade peniana. Ocorreu correcção completa da curvatura em 2 dos doentes mantendo os restantes doentes curvatura residual, sem incomodo nas relações sexuais. Não ocorreram complicações no pós-operatório.

Discussão/Conclusões: O tratamento de Doença de Peyronie com enxerto de TachoSil é reprodutível e promissor. A sua utilização permite uma maior facilidade na aplicação do enxerto com redução do tempo cirúrgico. Um efeito hemostático acrescido parece ser também uma das vantagens desta técnica.

P 03

SÍNDROME DE ZINNER – UMA ETIOLOGIA INCOMUM DE DOR ESCROTAL

Débora Araújo[1]; Daniela Pereira[1]; Raquel Rodrigues[1]; Alexandre Gromicho[2]; Pedro Costa[1]; Sofia Florim[1]; Jorge Dias[1]; Vitor Oliveira[1]; Luís Ferraz[1]

[1]CHVN Gaia/Espinho; [2]Hospital Central do Funchal

Introdução: O síndrome de Zinner (SZ) constitui uma malformação congénita rara do ducto mesonéfrico que ocorre no 1º trimestre de gestação, caracterizando-se pela tríade de agenesia renal unilateral, formações quistícas da vesícula seminal e obstrução do canal ejaculatório ipsilateral. Atualmente existem apenas cerca de 120 casos reportados. Tornam-se sintomáticos por volta da 2ª-3ª década de vida, clinicamente apresentando queixas inespecíficas como desconforto/dor escrotal. Adicionalmente, podem ser detetados durante o estudo de infertilidade masculina.

Caso clínico: Sexo masculino, 21 anos, caucasiano, sem antecedentes pessoais de relevo com queixas apenas de dor escrotal intermitente com 4 meses de evolução. Verificou-se a presença de um epidídimo direito aumentado sem sinais inflamatórios. Ecograficamente diagnosticou-se agenesia renal direita e detectou-se uma imagem nodular pélvica direita que a ressonância magnética (RM) pélvica confirmou tratar-se de uma dilatação quística da vesícula seminal direita. Na RM observou-se também uma dilatação do canal deferente direito em todo o seu trajeto, aspeto sugestivo de obstrução do canal ejaculatório; não se visualizou ureter nem meato ureteral direito. Fez-se o diagnóstico de SZ. Realizou um estudo hormonal e espermograma que estavam normais. Decididiu-se manter tratamento conservador com analgesia dado o carater esporádico dos sintomas e ausência de alterações de fertilidade.

Conclusão: O SZ é um síndrome de diagnóstico díficil e, muitas das vezes, tardio por causa da inespecificidade clínica e da paucidade de casos clínicos. A RM estabece o diagnóstico definitivo. O tratamento deve ser conservador quando assintomáticos ou com sintomas ligeiros, reservando-se o tratamento cirúrgico para os casos sintomáticos.

P 04

QUALIDADE ESPERMÁTICA: QUAL O IMPACTO DO TEMPO DE CRIOPRESERVAÇÃO E DA UTILIZAÇÃO DE CRIOPROTETOR?

Pinho, P.[1,2]; Arantes, R.[1,3]; Gomes, Z.[4]; Brito, M.[4], Moutinho, O.[4], Colaço, B.[3], Pinto Leite, R.[1]

[1]Laboratório de Genética/Andrologia, Hospital de Trás-os-Montes e Alto Douro, Vila Real, Portugal; [2]Departamento de Genética e Biotecnologia, Universidade de Trás-os-Montes e Alto Douro, Vila Real, Portugal; [3]Centro de Investigação e de Tecnologias Agroambientais e Biológicas (CITAB), Universidade de Trás-os-Montes e Alto Douro, Vila Real, Portugal; [4]Departamento de Obstetrícia e Ginecologia, Vila Real, Portugal

A criopreservação é uma técnica imprescindível na área da procriação medicamente assistida. Contudo, no congelamento-descongelamento de sémen, podem ocorrer vários processos biológicos que danificam as células.

Este estudo teve por objetivo avaliar a influência do tempo e método de criopreservação na qualidade espermática.

Realizou-se a análise espermática em 55 amostras anonimizadas a fresco e, em 31 amostras após uma semana, 1 mês e 3 meses de criopreservação (vapores de nitrogénio líquido, seguido de imersão); em 24 amostras após 1 mês de criopreservação com crioprotetor e em 11 destas após criopreservação sem crioprotetor e por imersão direta da amostra, em criotubo. Nas 24 amostras avaliou-se a percentagem de mitocôndrias ativas. Para análise estatística utilizou-se o IBM SPSS Statistics 25 software.

O período de criopreservação não mostrou influenciar a qualidade espermática. No entanto, o método de criopreservação aplicado sim. Nas 31 amostras criopreservadas, a motilidade e vitalidade diminuíram em média 96% e os espermatozoides típicos 79%. Nas 24 amostras, estes parâmetros e as mitocôndrias ativas diminuíram, em média, 61%, bem como a concentração (42%). As caudas "anormais" triplicaram . Os resultados das 11 amostras foram semelhantes entre si e aos obtidos para as 31 amostras após criopreservação.

Os resultados encontram-se de acordo com a literatura, não se verificando influência do período de criopreservação na qualidade das amostras após descongelamento, mas sim do método aplicado. Apesar de obtidos melhores resultados quando utilizado crioprotetor, é necessário testar mais protocolos com diferentes taxas de congelamento/descongelamento, de modo a minimizar-se o impacto negativo na qualidade espermática.

P 05

TORÇÃO DO CORDÃO ESPERMÁTICO NO ADULTO: EXPERIÊNCIA DE UM CENTRO

Francisco Fernandes; Hugo Pinheiro; Gil Falcão; Rui Bernadino; Thiago Guimarães; Vanessa Andrade; Fernando Calais; Luis Campos Pinheiro
Centro Hospitalar de Lisboa Central

Introdução: A torção do cordão espermático (TCE) tem maior prevalência na adolescência, contudo estima-se que 39% dos casos possam ocorrer na vida adulta.

Objectivos: Avaliar a apresentação clínica dos doentes submetidos a exploração escrotal urgente (EEU) por suspeita de TCE e potenciais factores contributivos para o diagnóstico diferencial.

Métodos: Analise retrospectiva dos processos dos 92 doentes submetidos a EEU por suspeita de TCE entre 01-2010 e 12-2017. Em função do diagnóstico cirúrgico, os doentes foram divididos em dois grupos: Grupo 1 – doentes com TCE; Grupo 2 – outras patologias (orquiepididimite, trauma escrotal). Foram comparados dados da história clínica, exame objectivo e resultados de Doppler ecográfico escrotal (DEE).

Resultados: O Grupo 1 incluiu 70 doentes (76%) e o Grupo 2 continha 22 doentes (24%). O Grupo 2 apresentou uma média de idades superior (26.9 vs. 23.8). Não se verificaram diferenças quanto à duração da dor escrotal, no entanto a presença de testículo em posição anormal foi mais frequente no Grupo 1 (76% vs. 36%). Não existiram diferenças significativas relativamente à existência de febre, eritema ou edema escrotal, e dor à palpação testicular entre os 2 grupos. A taxa de salvação testicular foi de 76%. Foi realizada DEE em 43 doentes com uma especificidade de 100%.

Discussão/Conclusões: A TCE constitui a causa mais frequente para EEU no adulto. Os achados clínicos aliados ao DEE parecem desempenhar um papel importante no diagnóstico diferencial.

P 06

PRIAPISMO DE BAIXO DÉBITO E FUNÇÃO ERÉTIL PÓS-TRATAMENTO

Rui Bernardino; Luis Severo; Gil Falcão; Francisco Fernandes; Vanessa Andrade; Thiago Guimarães; Luis Campos Pinheiro
Centro Hospitalar de Lisboa Central

Introdução: O priapismo é uma emergência urológica incomum que pode levar à impotência se o doente não for intervencionado. Existem três tipos: isquémico (priapismo de baixo débito) (PBD), não-isquémico (alto débito) e isquémico recorrente (intermitente).

Objetivos: Este trabalho tem como objetivo ava-

liar a eficácia de vários métodos de tratamento e os fatores de risco para a disfunção erétil (DE) em pacientes com PBD.

Material e métodos: Entre janeiro de 2010 e janeiro de 2018, 26 pacientes com priapismo foram tratados no nosso serviço. Após revisão retrospectiva da história clínica do paciente, exame objectivo, análises e gasometria cavernosa, foram identificados 21 pacientes com PBD. A função erétil após o tratamento foi avaliada através do questionário: Índice Internacional de Função Erétil (IIEF-5).

Resultados: As causas do priapismo foram injeção intracavernosa em 3 casos, idiopática em 7 casos, distúrbios hematológicos e drogas recreativas em 3 casos e toma de inibidores da fosfodiesterase tipo 5 em 5 pacientes. Onze pacientes foram observados após mais de 48 horas depois do início do Priapismo. A aspiração de sangue dos corpos cavernosas e a injeção intracavernosa com simpatomiméticos foram realizados em todos os pacientes. Em 18 pacientes (17 dos quais com Priapismo há mais de 48 horas antes), a falha do tratamento conservador levou à intervenção cirúrgica (6 procedimentos de Winter e 12 procedimentos de Al-Ghorab). Em dois casos, um shunt proximal (quackels) foi realizado por falha do shunt distal. Onze pacientes (52,3%) referiram disfunção erétil após o tratamento. Todos os pacientes nos quais o shunt cavernoglandular foi realizado mencionaram deterioração subsquente da função erétil.

Discussão/Conclusões: O priapismo requer avaliação e tratamento imediatos. Em pacientes com PBD, o atraso na procura do Urologista e intervenções cirúrgicas agressivas induzem ED em quase todos os pacientes. A falha na avaliação e tratamento rápidos pode resultar em morbidade significativa.

P 07

SÉMEN: O ESPELHO DO ESTILO DE VIDA

Teresa Reis Araújo; Carina Freitas; Leonor Silva Jorge; Bruno G. Silva; Gonçalo Melo
USF Tílias

Introdução: A qualidade do sémen e a fertilidade masculina estão em declínio em todo o mundo, o que parece estar associado a fatores comportamentais e ambientais de estilo de vida (EV), nomeadamente tabagismo, consumo excessivo de álcool, dietas hipercalóricas, obesidade, alterações do sono, stress psicológico, aumento da temperatura escrotal, entre outros.

Objetivos: Averiguar os fatores de EV com impacto na qualidade dos parâmetros seminais. Sensibilizar para a importância de um EV saudável na otimização do potencial reprodutivo.

Material/Métodos: Pesquisa na PubMed; últimos 3 anos; incluídos artigos de revisão, meta-análises e ensaios clínicos controlados e aleatorizados; termos MeSH "sperm quality" e "lifestyle". Obtiveram-se 51 artigos, dos quais 26 foram excluídos após leitura do abstract e pela pertinência.

Resultados: Relatam-se alguns dados: tabagismo - redução de 13-17% na concentração de espermatozoides, aumento de aneuploidias e mutações; consumo excessivo de álcool (40-80 gr/dia) – redução do volume de sémen, teratozoospermia em 63% dos casos; dieta mediterrânica – associada positivamente à qualidade do sémen; obesidade – maior percentagem de mutações, alterações mitocondriais e da morfologia dos espermatozoides; pert. sono – redução do volume do sémen estudado na insónia inicial; stress emocional significativo (HADS >=8) – redução da concentração de espermatozoides e da sua motilidade; aumento da temp. escrotal – apoptose de células germinativas e mutações.

Discussão: O processo da espermatogénese pode ser influenciado por fatores de EV que são modificáveis. As recomendações para um estilo de vida saudável devem não só ser abordadas no homem infértil, como também enquanto

estratégia preventiva para otimizar o potencial reprodutivo.

P 08

EFEITOS DOS DISRUPTORES ENDÓCRINOS NAS ESPERMATOGÓNIAS ESTAMINAIS: ONDE SE ENQUADRA O PAPEL PROTETOR DA REGUCALCINA?

Sara Correia[1]; Mariana Feijó[1]; João Ramalho-Santos[2]; Ans van Pelt[3]; Sílvia Socorro[1]
[1]CICS-UBI - Centro de Investigação em Ciências da Saúde, Universidade da Beira Interior, Av. Infante D. Henrique, 6200-506 Covilhã, Portugal; [2]CNBC - Centro de Neurociências e Biologia Celular, Universidade de Coimbra, Largo Marquês de Pombal, 3004-517, Coimbra, Portugal; [3]AMC - Academic Medical Center, Reproductive Biology Laboratory, Center for Reproductive Medicine, University of Amsterdam, Meibergdreef 9, 1105 AZ Amsterdam, The Netherlands

Nas últimas décadas tem sido demonstrado que a exposição a desreguladores endócrinos (EDs), in utero ou nas fases iniciais da vida, pode perturbar a sinalização hormonal, levando a defeitos congénitos, distúrbios comportamentais, alterações da espermatogénese, e até mesmo a neoplasias. Modificações que podem ainda ser transmitidas às gerações futuras. As células estaminais espermatogoniais (SSCs) estão na base do processo espermatogénico e da transmissão da informação genética. No entanto, pouco se sabe sobre o impacto dos EDs neste tipo de células. A regucalcina (RGN) é uma proteína de ligação ao cálcio associada à função reprodutiva masculina pelo seu papel protetor no controlo do stress oxidativo, proliferação celular, apoptose e metabolismo. Este trabalho pretendeu analisar a ação da RGN minimizando os efeitos dos EDs nas SSCs. Para este fim, SSCs de rato transfetadas de modo a sobrexpressar RGN e células com expressão basal foram expostas ao xenoestrogénio metoxicloro (MXC, 25 µM, 48 horas), sendo, posteriormente, avaliadas a atividade glicolítica e apoptose. Os resultados obtidos mostraram um aumento do fluxo glicolítico nas SSCs com o tratamento com MXC, efeito que foi atenuado pela sobrexpressão da RGN. A RGN contrariou também o aumento da morte celular induzida pelo MXC. O presente estudo, sendo o primeiro a evidenciar a modulação do metabolismo e da apoptose das SSCs por fatores hormonais, demonstra que estas células são um alvo direto dos EDCs, nomeadamente do MXC. Identificou-se ainda a RGN como um fator protetor contra os efeitos nocivos dos EDcs nas SSCs e, consequentemente, na fertilidade masculina.

P 09

HIPERESTROGEMISMO, APOPTOSE DAS CÉLULAS GERMINATIVAS E INFERTILIDADE MASCULINA: EXISTE RELAÇÃO?

Sara Correia; José Eduardo Cavaco; Sílvia Socorro
CICS-UBI, Centro de Investigação em Ciências da Saúde, Universidade da Beira Interior

A espermatogénese é estritamente dependente da ação das hormonas esteroides sexuais, as quais regulam os eventos celulares e moleculares subjacentes ao desenvolvimento das células germinativas. Os estrogénios são importantes reguladores da proliferação celular e apoptose em vários tipos de tecidos. No entanto, os seus efeitos na espermatogénese permanecem controversos, dado que alguns estudos apontam os estrogénios como fatores de sobrevivência enquanto outros os identificam como indutores da apoptose. A revisão da literatura demonstrou a existência de concentrações aumentadas de estrogénios no soro, veia espermática e fluído intratesticular de homens inférteis, o que sustenta uma ação prejudicial destas hormonas na espermatogénese. O presente estudo investigou o efeito de estrogénios na regulação da apoptose nos túbulos seminíferos (SeT) e na comunicação células de Sertoli-células germinativas. SeT de rato foram mantidos em cultura na presença ou ausência de 100 nM 17 b-estradiol (E2), uma concentração que mimetiza as encontradas nos testículos de pacientes infér-

teis. A exposição ao E2 desregulou a expressão do stem cell factor (SCF, células de Sertoli) e do seu receptor c-kit (células germinativas), um sistema crucial na regulação da sobrevivência e morte das células germinativas. A expressão alterada do SCF/c-kit traduziu-se no aumento da apoptose das células germinativas, como evidenciado pelo aumento do ratio proteínas proapoptóticas/antiapoptóticas e aumento da atividade das proteínas executoras de apoptose. Concomitantemente, o E2 diminuiu a proliferação nos SeT o que foi determinado pela análise imunohistoquímica do marcador de proliferação Ki67. Em conclusão, altas concentrações de E2 desequilibraram o sistema SCF/c-kit com impacto na sobrevivência das células germinativas. Os presentes resultados suportam a ligação entre hiperestrogenismo e infertilidade masculina idiopática, e fornecem uma base justificativa para abordagens terapêuticas visando os mecanismos de sinalização dos estrogénios.

P 10

AVALIAÇÃO DOS FATORES DE RISCO ASSOCIADOS A DOENÇA DE PEYRONIE EM DOENTES SUBMETIDOS A CORREÇÃO CIRÚRGICA NO CHLC

Thiago Guimarães; Ciprian Muresan; Luís Campos Pinheiro
Centro Hospitalar Lisboa Central

Introdução: A Doença de Peyronie é uma patologia benigna e adquirida de etiologia desconhecida e de prevalência subestimada.
Objetivo: Avaliar os fatores de risco associados a Doença de Peyronie em pacientes submetidos a correção cirúrgica no Centro Hospitalar Lisboa Central (CHLC).
Materiais e métodos: Foram avaliados todos os doentes submetidos a cirurgia para correcção da Doença de Peyronie entre janeiro de 2009 e Dezembro de 2017. Os dados da amostra foram recolhidos através da consulta informática do processo clínico e por contato telefónico. Foram considerados como paramêtros a idade, a presença de Hipertensão Arterial, Dislipidémia, Obesidade, Tabagismo, Alcoolismo, história de trauma, Doença de Dupuytren ou intervenção urológica recente.
Resultados: Foram avaliados 90 doentes. A média de idades foi de 68,9 anos. Os principais fatores de risco associados a Doença de Peyronie nesta amostra foram a Hipertensão Arterial (45%), Dislipidémia (31%) e tabagismo (27%) e a Diabetes Mellitus (19%). O grau e a gravidade da curvatura se relacionaram com o número de fatores de risco associados.
Conclusão: Os fatores de risco como Hipertensão Arterial, Dislipidémia, Tabagismo e Diabetes Mellitus parecem ter um grande impacto na gravidade dos sintomas e no grau de curvatura relacionados a Doença de Peyronie.

P 11

ALIMENTOS COM INFLUÊNCIA NA SAÚDE SEXUAL E REPRODUTIVA

Tânia Silva; Mariana Jesus; César Cagigal; Carla Silva
Centro Hospitalar e Universitário de Coimbra, CRI Psiquiatria

Introdução: A disfunção sexual e a infertilidade são condições com alta prevalência na população geral. Fatores nutricionais têm sido relatados como tendo impacto na saúde sexual e reprodutiva.
Objetivo: O objetivo desta revisão é resumir os dados sobre fatores que influenciam a função sexual e reprodutiva masculina e feminina, incluindo o estado nutricional, alimentos específicos (por exemplo, alimentos lácteos), nutrientes e outros componentes alimentares e suplementos dietéticos.
Método: Foi realizada uma pesquisa bibliográfica nas bases de dados Cochrane Library, Medline e ScienceDirect, sem limitações de tempo.
Resultados: A obesidade tem uma influência negativa na fertilidade masculina e a perda de peso melhora a fertilidade masculina. A insufi-

ciência alimentar está associada ao aumento de comportamentos sexuais de risco, mais relevantes na mulher. Em relação aos macronutrientes e grupos alimentares, os ácidos gordos trans, alimentos com alto índice glicémico, dieta rica em hidratos de carbono e isoflavonas de soja (nos homens) prejudicam a fertilidade; Os ácidos gordos ómega-3 e ómega-6, proteínas vegetais, antioxidantes e leite gordo melhoram a fertilidade. Em relação aos suplementos dietéticos, a maioria dos produtos carece de evidências que sustentem sua eficácia e as substâncias mais promissoras são a ioimbina em pacientes com disfunção erétil, vitaminas do complexo B em pacientes com hiper-homocisteinemia, L-arginina em doentes com disfunção endotelial relacionada com óxido nítrico e vitamina D em pacientes com deficiência desta vitamina.

Conclusão: Os resultados compilados indicam que, apesar da etiologia multifatorial da disfunção sexual / reprodutiva, fatores nutricionais podem afetar a saúde sexual e reprodutiva em homens e mulheres. No entanto, são necessários novos estudos para esclarecer essa associação e, simultaneamente, melhorar a abordagem e o tratamento de pacientes com problemas sexuais e / ou reprodutivos.

P 12

PRIAPISMO RECORRENTE SECUNDÁRIO A TRAZODONA – UM RARO MAS IMPORTANTE EFEITO SECUNDÁRIO

Débora Araújo[1]; Daniela Pereira[1]; Raquel Rodrigues[1]; Alexandre Gromicho[2]; Pedro Costa[1]; Jorge Dias[1]; Luís Ferraz[1]

[1]CHVN Gaia/Espinho; [2]Hospital Central do Funchal

Introdução: O priapismo recorrente é uma variante do priapismo isquémico caraterizado por ereções prolongadas e dolorosas intermitentes. São emergências urológicas que podem cursar com disfunção sexual irreversível e, em casos mais graves, em necrose do órgão-alvo. Cerca de 30% dos casos são induzidos por fármacos, e destes 80% são provocados pela trazodona. A trazodona é um antidepressivo atípico com grande uso na prática clínica pelas suas propriedades sedativas e antidepressivas. A incidência de priapismo em doentes medicados com trazodona é baixa e na maioria dos casos a terapêutica já está instituída há algum tempo.

Caso clínico: Sexo masculino, caucasiano, 43 anos, medicado apenas com trazodona 100mg por insónia terminal há 18 meses. Referenciado à consulta externa de Urologia por episódios de novo de ereções dolorosas (duração média de 10 horas), que cediam apenas com o esforço físico intenso com 6 meses de evolução. Sem outros antecedentes pessoais de relevo nomeadamente história de traumatismos penianos e perianais, consumos etílicos e toxicómanos. Exame objetivo sem alterações. Sem discrasias sanguíneas. A sintomatologia desapareceu com a suspensão do fármaco.

Conclusão: A relação da trazodona com o priapismo está bem documentada. Mesmo com o tratamento atempado do priapismo, cerca de 40-50% dos doentes podem ficar com uma disfunção sexual permanente. Apesar de grave, o priapismo induzido pela trazodona é um efeito secundário raramente abordado e inclusive subvalorizado na prática clínica. Dada a crescente aplicabilidade deste fármaco, é importante insistir na importância de alertar estes doentes sobre este raro mas significativo efeito secundário.

P 13

TUMOR DE CÉLULAS DE LEYDIG DE COMPORTAMENTO MALIGNO – DESCRIÇÃO DE 2 CASOS RAROS

Débora Araújo[1]; Daniela Pereira[1]; Raquel Rodrigues[1]; Alexandre Gromicho[2]; Pedro Costa[1]; Jorge Dias[1]; Liliana Santos[1]; Xiaogang Wen[1]; Agostinho Sanches[1]; Luís Ferraz[1]

[1]CHVN Gaia/Espinho; [2]Hospital Central do Funchal

Introdução: Os tumores de c0élulas de Leydig (TCL) são neoplasias raras, correspondendo a

cerca de 1-3% dos tumores do testículo; apenas 10% destes tumores são malignos. Existem características morfo-histológicas sugestivas de malignidade, contudo a metastização é o único critério definitivo.

Caso 1: Sexo masculino, 60 anos, com uma massa testicular esquerda volumosa. Ecograficamente detetadas múltiplas lesões testiculares nodulares bilaterais. Estudo anatomo-patológico após biópsia testicular revelou um TCL de cerca de 50mm com caraterísticas sugestivas de malignidade. Faleceu cerca de 2 meses após o diagnóstico com metastização hepática e óssea. Foi realizada biópsia hepática que confirmou envolvimento secundário por neoplasia primária do testículo.

Caso 2: Jovem, 24 anos, azoospérmico, com queixas de desconforto escrotal direito; sem alterações ao exame físico. Imagiologicamente detetado nódulo testicular direito com cerca de 8mm. Após orquidectomia radical direita, estudo anatomo-patológico mostrou TCL com caraterísticas sugestivas de malignidade. Sem diagnóstico de doença metastática até à data.

Conclusão: O seguimento e as opções terapêuticas do TCL, sobretudo perante características sugestivas de malignidade e/ou doença metastática comprovada, permanece controverso. Estas neoplasias são quimio e radiorresistentes, conferindo a malignidade um prognóstico reservado.

P 14

SÍNDROME DE KLINEFELTER – UMA CAUSA GENÉTICA DE INFERTILIDADE MASCULINA

Vanessa Andrade; Mariana Medeiros; Thiago Guimarães; Rui Bernardino; Gil Falcão; Francisco Fernandes; Rui Farinha; Fortunato Barros; Luís Campos Pinheiro

Centro Hospitalar de Lisboa Central – Hospital de São José

Um indivíduo do sexo masculino, 34 anos, foi referenciado à consulta externa de Urologia por infertilidade. Ao exame objectivo constatou-se uma diminuição bilateral do volume testicular e, analiticamente, aumento das gonadotrofinas. No espermograma verificou-se oligoastenoteratozooespermia. Por suspeita de síndrome genético foi solicitado um cariótipo, cujo resultado – 47, XXY – foi compatível com Síndrome de Klinefelter.

O síndrome de Klinefelter é a a causa genética mais comum de infertilidade masculina. Estes doentes têm uma apresentação fenotípica extremamente variável, indo desde um fenótipo típico até poder passar completamente despercebido à apresentação, como ocorreu neste doente. Muitos doentes com síndrome de Klinefelter estão mal diagnosticados ou continuam sem diagnóstico. Apenas 25% estão correctamente diagnosticados e a maioria destes diagnósticos não são feitos até à idade adulta, de que é exemplo este caso clínico. Apesar de ser uma das etiologias de infertilidade, é possível intervir nestes doentes através de técnicas de procriação medicamente assistidas o que permite, por vezes, dar oportunidade a estes homens de terem um filho biológico.

P 15

NEM TUDO O QUE PARECE É: MULHER 46, XY

Ema Santos; Pedro Francisco Fernandes; Kathleen Brazão; Filipa A. Santos; Alexandre Gromicho; Jorge Lima Fernandes; Duarte Saunders; Artur Real; João Faria Nunes; Manuel Serrão; Ferdinando Pereira

Hospital Central do Funchal

Introdução: O síndrome de Insensibilidade Completa aos Androgénios (CAIS) é uma doença recessiva ligada ao X causada por mutação no gene do recetor androgénico. É uma patologia do desenvolvimento sexual com uma incidência de 1/20000-100000 nados vivos do sexo masculino. Carateriza-se pela presença de genitais externos femininos em indivíduos 46,XY com testículos criptorquídicos e ausência de resposta a níveis de androgénios apropriados para a idade. A apresentação típica é amenorreia primária num adolescente do sexo feminino.

Caso clínico: Adolescente de 17 anos, sexo feminino, sem antecedentes pessoais de relevo, referenciada à ginecologia por amenorreia primária. Fenotipicamente com desenvolvimento mamário normal, escassos pêlos púbicos, genitais externos de aparência adequada. Exame ginecológico evidenciou uma vagina em fundo cego, não se palpando o útero. Sem massas inguinais palpáveis. Avaliação hormonal revelou elevação da testosterona sérica (9,43 ng/mL). Cariótipo 46, XY. RM pélvica identificou duas estruturas compatíveis com gónadas, uma à direita da bexiga e outra adiante do músculo Psoas esquerdo, ausência das estruturas Mullerianas. Submetida a gonadectomia bilateral profilática por via laparoscópica. Exame histológico confirma testículos com túbulos imaturos rodeados por células de Leydig, sem neoplasia. Iniciou terapêutica hormonal de substituição com estradiol.
Conclusão: Apesar de geneticamente 46,XY, indivíduos com CAIS são fenotipicamente do sexo feminino e, como tal, necessitam de um acompanhamento psicológico, sendo a orientação psico-sexual feminina a aconselhada. Dado o elevado risco de transformação maligna das gónadas pós-puberdade, é recomendado a orquidectomia profiláctica com subsequente substituição hormonal com estradiol para manter as características sexuais secundárias e densidade mineral óssea.

P 16

PRÓTESE PENIANA: EXPERIÊNCIA DOS ÚLTIMOS 8 ANOS DO SERVIÇO DE UROLOGIA DO CHLN

Carolina Borges da Ponte; Ricardo Pereira e Silva; Sandro Gaspar; Anatoliy Sandul; Pedro Oliveira; Afonso Castro; João Gomes; José Palma dos Reis; Tomé Lopes
Serviço de Urologia do Centro hospitalar Lisboa Norte

Introdução: A colocação de prótese peniana constitui um tratamento definitivo da disfunção erétil refratária a outra terapêutica em doentes motivados.
Objectivos: Avaliar as indicações, o outcome cirúrgico, complicações pós-operatórias e satisfação do doente.
Material e métodos: Análise retrospetiva de todos os doente submetidos a colocação de prótese peniana entre 2009 e 2017. Os dados foram colhidos mediante consulta do processo clínico e a satisfação foi avaliada através de um questionário por entrevista telefónica.
Resultados: Amostra total com 45 doentes; foram colocadas 41 próteses insufláveis e 4 semi-rígidas, todas por incisão peno-escrotal. A idade média na altura do procedimento foi 61,5 anos. A principal etiologia de disfunção erétil foi vascular (70%); outras causas foram pós prostatectomia radical (13%), pós resseção anterior do recto (4%), pós-traumática (2%). O tempo médio de internamento foi de 2 dias e ocorreram complicações pós-operatórias em 15% dos casos: 5 doentes apresentaram infeção da prótese, 3 com necessidade de explantação. Resultado funcional a longo prazo: 58% dos doentes responderam a questionário de satisfação, sendo que 74% dos doentes estavam com prótese funcional e satisfeitos com a cirurgia, apesar de 2 doentes serem incapazes de manusear o dispositivo e 1 encontrar-se a aguardar cirurgia de revisão por não funcionamento da prótese.
Discussão/Conclusão: A principal complicação pós-operatória foi infeção da prótese, embora infrequente. A maioria dos doentes estava satisfeita com o resultado funcional. A prótese peniana mantém-se uma opção viável e eficaz no tratamento da disfunção eréctil refratária a outra terapêutica ou em caso de intolerância.

P 17

DISFUNÇÕES SEXUAIS EM HOMENS QUE FAZEM SEXO COM HOMENS (HSH): UMA REVISÃO DA LITERATURA

Lucas Lopes; Irina Carvalho; Sara Pereira
Centro Hospitalar de Vila Nova de Gaia e Espinho

Introdução: Apesar do conhecimento existente

sobre disfunções sexuais masculinas, a investigação tem-se centrado em práticas sexuais heterossexuais.

Objetivos: Este trabalho pretende explorar e resumir os dados relativos a disfunções sexuais em HSH.

Material e métodos: Este trabalho consiste numa revisão não sistemática da literatura disponível em bases de dados eletrónicas (ex. MEDLINE).

Resultados: Os estudos que abordam as disfunções sexuais em HSH apresentam entre si diferenças metodológicas e limitações. Contudo estudos reportam preocupações sexuais a rondar os 50-80% dos participantes, podendo uma maior frequência estar relacionada com a intensidade da homofobia internalizada.

Relativamente a dificuldades de ereção, estudos apontam uma maior frequência em HSH do que em homens que fazem sexo com mulheres, indicando ainda que a ansiedade de performance poderá ser mais elevada em HSH.

Quanto a ejaculação prematura não são reportadas diferenças. Todavia os problemas ejaculatórios parecem ser mais prevalentes em HSH que se envolvem em comportamentos sexuais de risco ou vivem sob stress significativo (ex. baixa aceitação).

Diversos estudos investigaram as disfunções sexuais em HSH após patologias como o cancro da próstata. Estes revelaram um maior decréscimo da qualidade de vida em homossexuais comparativamente a heterosexuais, pela menor ridigez da ereção obtida e redução do volume ejaculado.

Discussão/Conclusões: Os pacientes que se apresentam com disfunções sexuais podem envolver-se em práticas sexuais não heterossexuais, sendo por isso necessário questionar sobre as práticas sexuais.

Nao obstante, torna-se fundamental investigar e compreender melhor o impacto das disfunções sexuais na população HSH, tendo em conta as suas particularidades, disponibilizando cuidados de saúde adequados e competentes.

P 18
DISFUNÇÃO SEXUAL APÓS A TRANSPLANTAÇÃO RENAL

Renato Lains Mota[1]; Rita Fonseca[1]; José Carlos Santos[1]; Helder Monteiro[1]; Domingos Machado[1]; Jorge Cardoso[2]

[1]Centro Hospitalar de Lisboa Ocidental; [2]Instituto Universitário Egas Moniz

A sexualidade é uma dimensão significativa da qualidade de vida global (QoL) e da qualidade de vida associada à saúde (HRQoL), sendo no transplantado renal influenciada por diversos factores biopsicossociais. A disfunção sexual após a transplantação renal presume-se multifactorial e exerce um impacto negativo sobre a satisfação sexual, QoL e HRQoL.

Este estudo teve como objectivo avaliar a função sexual masculina, a satisfação sexual e a satisfação com a imagem corporal após transplantação renal, numa amostra de conveniência do Centro Hospitalar de Lisboa Ocidental com recurso ao International Index of Erectile Satisfaction,New Scale of Sexual Satisfaction, Brief Symptom Inventorye Body Image Scale.

A taxa de resposta foi de 27.2% diagnosticando-se disfunção eréctil em 66.1% da amostra. Encontrou-se uma correlação entre o funcionamento e a satisfação sexual ($r=.598$; $p<.01$; $n=112$) e entre satisfação com a imagem corporal e a função sexual ($r=-.193$; $p<.05$; $n=112$). O tempo decorrido após a transplantação (36meses) não evidenciou diferença na função e na satisfação sexual.

Estes resultados apontam para uma elevada taxa de disfunção sexual face à prevalência conhecida para a população geral. Verificou-se uma relação entre a função sexual e a satisfação sexual. A imagem corporal mais satisfatória associou-se a um melhor funcionamento sexual mas não a maior satisfação sexual reflectindo provavelmente os mecanismos de ajustamento que a satisfação sexual tende a manter ao longo da vida de um indivíduo. Permanece por determinar de modo longitudinal o efeito da transplantação renal sobre a sexualidade e a imagem corporal.

P 19

ALPROSTADIL INTRAURETRAL NA PRÁTICA CLÍNICA

Mário Lourenço; Miguel Eliseu; João Carvalho; Belmiro Parada; Arnaldo Figueiredo
Serviço de Urologia e Transplantação Renal, CHUC

Introdução: O alprostadi intrauretral (AIU) foi originalmente apresentado como uma terapia de 2ª linha, em casos de disfunção erétil (DE) refratários a tratamento com inibidores da fosfodiesterase 5 (IFD5).

Objetivos: Comparar a resposta ao tratamento de doentes com DE tratados com IFD5, AIU em 1ª linha e AIU em 2ª linha.

Métodos: 55 doentes com DE foram avaliados pelo mesmo médico, tendo respondido questionário completo de avaliação sexual, incluindo IIEF5. Todos os doentes com indicação terapêutica optaram entre AIU (G1) ou IIEF5 (G2). Na primeira reavaliação foi realizado novo questionário IIEF5 e avaliado o sucesso terapêutico (definido como qualquer diminuição no escalão de severidade de DE do IEFF5). Em caso de insucesso, a medicação foi alterada e os resultados reavaliados.

Resultados: Inicialmente, 12 doentes (21,9%) optaram por AIU e 37 (67,3%) por IIEF5. Não existiram diferenças estatisticamente significativas (p>0,05) entre os dois grupos relativamente à idade mediana, tempo de evolução mediano dos sintomas, presença de comorbilidades relevantes, IIEF mediano inicial e severidade da DE.

Relativamente aos resultados na 1ª reavaliação, a taxa de sucesso terapêutico na foi de 50,0% no G1 e de 45,5% no G2 (p>0,05).

9 doentes realizaram terapia de 2ª linha com AUI, apresentando uma taxa de sucesso de 77,7%.

A taxa de sucesso terapêutico na última avaliação, em doentes que realizaram AIU em qualquer momento do *follow-up*, foi de 82,4% (vs. 65,0%; p>0,05).

Discussão e conclusão: O AIU apresenta bons resultados como terapia de 1ª e de 2ª linha.

P 20

DISFUNÇÃO ERÉCTIL ASSOCIADA AO CICLISMO

Gonçalo Melo; Carina Freitas; Leonor Silva; Jorge Bruno G. Silva; Teresa Araújo
USF Tílias

Enquadramento: A disfunção eréctil (DE) masculina é uma doença que se caracteriza pela incapacidade de atingir e/ou manter ereção suficiente para ter uma performance sexual satisfatória. Cerca de 52% dos homens > 45 anos, são afetados em diferentes graus por esta patologia.

Descrição do caso: Em consulta de saúde de adultos, doente do sexo masculino de 43 anos, com antecedentes de obesidade, Hipertensão e dislipidémia medicadas e controladas, refere queixas de DE recente, de novo (nos últimos 2-3meses). Nega alterações da libido ou mais queixas a nível uro-sexual. Relação afetiva estável. Refere que relaciona início da DE com o início da prática regular de ciclismo, e melhoria dos sintomas aquando da interrupção da mesma. Ao exame objetivo apresentava um IMC de 27,3 (até há 1 ano era superior a 30); TA: 134/77 mmHg, FC 67 bpm, eupneico em ar ambiente. Sinais sexuais secundários presentes, sem sinais aparentes de deficiência em testosterona; sem alterações da sensibilidade a nível perineal; tónus rectal mantido; toque rectal indolor, sem evidência de aumento dimensional glandular ou nodularidade; reflexo cremasteriano mantido.

Propôs-se diminuição da prática de ciclismo para máximo de 3h semanais, alteração do selim para um mais largo, com melhor apoio das tuberosidades isquiais. Sugere-se uma maior adesão à terapêutica anti-hipertensora e anti--dsilipidémica. Caso estas medidas não resultem, pondera-se início de inibidores de PDE5 e/ou eventual avaliação em Medicina Física e de Reabilitação / Medicina Desportiva para adoção de melhorias ergonómicas na bicicleta.

Discussão: Será que a etiologia da DE se deve

aos antecedentes de hipertensão arterial, dislipidémia, prévia obesidade e sedentarismo do doente ou estará relacionado com o início da prática de ciclismo? Colocam-se ainda as questões de saber se seria vantajoso para o doente cessar a prática deste desporto ou se adoção de medidas como alteração do tipo de selim ou alteração da distância deste para os pedais poderiam ser medidas efetivas na diminuição da compressão perineal aquando da prática do ciclismo com capacidade para minorar as queixas de disfunção eretil.

P 21

A UTILIDADE DO ECODOPPLER PENIANO – UMA AVALIAÇÃO RETROSPECTIVA

Rita Fonseca; Renato Lains Mota; Inês Peyroteo; José Carlos Santos; Helder Monteiro
Serviço de Urologia do Hospital de Egas Moniz – Centro Hospitalar de Lisboa Ocidental

Introdução: O ecodoppler peniano avalia a resposta vascular peniana após estimulação farmacológica. É utilizado na avaliação da disfunção eréctil e no encurvamento peniano adquirido.
Objetivo: Apresentação da amostra seriada de ecodopplers penianos realizados no CHLO entre Janeiro de 2015 e Dezembro de 2017.
Material e métodos: Avaliação retrospectiva da casuística de ecodopplers realizados, respeitando o motivo de realização, factores de risco cardiovascular identificados e aspectos velocimétricos de resposta vascular peniana entre Janeiro de 2015 e Dezembro de 2017.
Resultados: Um total de 44 doentes submetido a eco-doppler peniano foi identificado.
Da população referenciada, 75,9% tinham queixas de disfunção eréctil (Grupo I), 6,9% apresentavam encurvamento peniano (Grupo II) e 6,9% tinham sobreposição destas duas patologias (Grupo III).
O pico sistólico médio direito (PSd) e esquerdo (PSe) após 20ug de alprostadilo foi, respectivamente, de 37,51 e 35,59 para grupo I, 51,65 e 30,85 para o Grupo II e 32,15 e 38,35 para grupo III. Metade dos doentes apresentavam alterações compatíveis com disfunção vascular. Em 34,09% houve mudança de terapêutica após realização de eco-doppler peniano.
Verificou-se associação estatisticamente significativa entre presença de dislipidemia e valor de PSd e PSe (p=0,11 e p=0,025, respectivamente).
Discussão e conclusões: Na abordagem da disfunção eréctil, o ecodoppler peniano é útil para distinguir entre etiologia orgânica e psicogénica. Neste estudo, as alterações vasculares arteriogénicas foram as mais frequentes, sendo concordante com o elevado número de factores de risco cardiovasculares presente. Assim, a realização deste exame permite direcionar a abordagem terapêutica de uma forma ajustada a cada doente.

P 22

SEXO-QUÍMICO: PENSAR A ARTICULAÇÃO ENTRE SERVIÇOS RELATIVOS AO USO DE SUBSTÂNCIAS E À SAÚDE SEXUAL

Filipe Couto Gomes; Marco Gonçalves; Mariana Silva; Tomás Teodoro
Centro Hospitalar Psiquiátrico de Lisboa

Introdução: O 'chemsex', que habitualmente implica o uso de mefedrona, GHB/GBL e/ou crystal meth, tem a particularidade de aumentar a excitação sexual e a duração das práticas sexuais, e desta forma, tornar mais intensos os encontros sexuais.
Objetivos: Com o presente trabalho, procura-se caracterizar tanto o fenómeno do 'chemsex' como o seu contexto relativamente aos homens que têm sexo com homens (HSH), identificando necessidades e sistematizando estratégias e intervenções.
Material e métodos: Procedeu-se a revisão da literatura partindo da base de dados Pubmed, motor de busca Google Scholar e materiais disponibilizados por equipas técnicas e organiza-

ções de base comunitária.
Resultados: O 'chemsex' é particularmente prevalente em áreas urbanas em que os HSH se concentram como residentes ou frequentadores de espaços de socialização e/ou locais de sexo. HSH que vivem com VIH estão sobre-representados nas amostragens de praticantes de 'chemsex'. O 'chemsex' é valorizado por alguns como 'facilitador' da intimidade e do conforto com o próprio corpo. Aos riscos relativos às infeções transmissíveis sexualmente e/ou pelo sangue (como na gestão dos riscos presentes no slamming e no fisting, por exemplo) e à sobredosagem (particularmente quanto ao GHB/GBL), podem somar-se o isolamento social, prejuízo laboral e económico e agravamento do estado mental. Entre as dimensões a integrar nas intervenções, pode apontar-se as repercussões do estigma e da discriminação relativos à não-heterossexualidade e à infeção pelo VIH.
Conclusões: Os serviços de saúde ligados ao uso de drogas, à saúde mental e à saúde sexual deverão procurar oferecer respostas multidisciplinares, informadas e consistentes, mitigando (auto-)estigmas.

P 23

VALOR PROGNÓSTICO DA ECOGRAFIA PENIANA COM DOPPLER EM DOENTES COM DISFUNÇÃO ERÉCTIL TRATADOS COM SILDENAFIL: RESULTADOS PRELIMINARES

Afonso Morgado1,2; Carlos Silva1,3;
[1]Serviço de Urologia, Centro Hospitalar São João; [2]Departamento de Biomedicina, Centro Hospitalar São João; [3]Departamento de Cirurgia e Fisiologia, Centro Hospitalar São João

Introdução: A ecografia peniana com doppler (EPD) tem sido utilizada no diagnóstico de disfunção eréctil(DE), sobretudo na avaliação do componente vasculogénico. Contudo, o seu valor prognóstico no tratamento da DE com inibidores da fosfodiesterase 5 não está ainda esclarecido.
Objetivo: Avaliação do valor preditor de resposta ao tratamento com sildenafil em doentes com disfunção eréctil tratados com sildenafil.
Material e métodos: Entre Janeiro de 2016 e Dezembro de 2018 trezentos doentes referenciados pelos cuidados de saúde primários por DE foram avaliados. Aqueles que cumpriam os critérios de inclusão e exclusão foram convidados a participar. Foram avaliados aos 0, 3 e 6 meses com os inquéritos validados IIEF-5 e VAS. Realizaram um EPD com 20ug de alprostadilo intra-cavernoso e iniciaram tratamento com sildenafil 100 mg aos 0 meses. Foram divididos em três grupos pela conclusão da EPD. IIEF-5 e VAS foram comparadas entre os grupos EPD normal e disfunção veno-oclusiva (DVO).
Resultados: Já completaram o protocolo 25, 18 e 5 doentes com EPD normal, DVO e insuficiência arterial, respetivamente. A média do IIEF-5 para EPD normal e DVO eram 24.58±0.93 vs 20.69±4.15 aos 3 meses e 25.00±0.00 vs 22.18±3.06 aos 6 meses, respetivamente. VAS aos 6 meses era de 9.75±0.61 vs 7.91±1.45. Houve uma diferença estatisticamente significativa no IIEF-5 aos 3 e 6 meses, bem como no VAS ($p=0.006$, $p=0.012$ e $p=0.002$ respetivamente).
Conclusão: O ecodoppler peniano pode ser um predizer a resposta ao tratamento com sildenafil na DE sendo o diagnóstico de DVO um preditor de pior resposta.

P 24

DISFORIA DE GÉNERO: LITERACIA PARA FAMILIARES E OUTRAS PESSOAS PRÓXIMAS

Filipe Couto Gomes; Beatriz Lourenço; Marco Gonçalves
Centro Hospitalar Psiquiátrico de Lisboa

Introdução e objetivos: O apoio da rede social e afetiva facilita a resiliência face à disforia de género e estigma. Esse apoio é também recurso valioso na adaptação à reconstrução sexual e transição social. Procurou-se incluir este aspeto no trabalho da equipa.
Material e métodos: Partindo da literatura relativamente ao impacto das respostas de familiares e outras pessoas próximas, e da experiência

com casos acompanhados, avançou-se para a criação de um espaço de literacia – designado TransParente - que lhes fornece esclarecimento por profissionais e oportunidade de partilha das experiências e dificuldades. Não sendo em si mesmo terapêutico, é parte do plano terapêutico individual que familiares e outras pessoas próximas participem no TransParente, sempre por proposta do paciente identificado.

Resultados: Os participantes do TransParente – até ao momento, familiares – têm valorizado a oportunidade para clarificar conceitos relativos ao género, esclarecer procedimentos clínicos de diagnóstico e terapêutica e refletir sobre a história do seu familiar e da própria família. Abordar dúvidas, conflitos e receios entre pessoas com vivências semelhantes, recebendo também aportes de profissionais de saúde mental, tem permitido que elaborem as dificuldades, mas também os ganhos, decorrentes desta mudança – e afirmação – relativamente ao género, à identidade e ao bem-estar da pessoa trans. Alguns participantes identificam como importante puderem vir a aceder a intervenção terapêutica familiar.

Conclusões: A adaptação de familiares e outras pessoas próximas, incluindo a literacia de género e questões trans, é um aspecto a valorizar na intervenção, promovendo um melhor prognóstico. Um contacto frequente com a rede social leva à identificação de necessidades e ferramentas adicionais.

P 25

DISFUNÇÃO ERÉCTIL: 6 ANOS DE FOLLOW-UP APÓS COLOCAÇÃO DE PRÓTESE PENIANA SEMI-RÍGIDA/ INSUFLÁVEL

Gil Falcão; Mariana Medeiros; Vanessa Andrade; Thiago Guimarães; Rui Bernardino; Francisco Fernandes; Cabrita Carneiro; Jorge Morales; Fortunato Barros; Luis Campos Pinheiro
Centro Hospitalar Lisboa Central

Introdução: A disfunção eréctil (DE) tem um impacto crescente a nível mundial com repercussões significativas a nível sexual e na qualidade de vida (QoL) pelo que é necessário uma correcta avaliação dos doentes onde se podem incluir questionários como o IIEF5 (International Index for Erectile Function). Estes permitem avaliar diferentes domínios da função sexual assim como o potencial impacto de uma determinada modalidade de tratamento. Uma vez determinada a etiologia da DE, o tratamento deve ser iniciado usando terapias médicas conservadoras tais como os inibidores da Fosfodiesterase (iPDE5), avançando para as formas mais invasivas como a colocação de prótese peniana.

Objectivos/Material/Métodos: Demonstrar os resultados em termos de complicações e satisfação de 46 doentes submetidos à colocação de próteses penianas semi-rígidas (PPSR) e insufláveis (PPI) no CHLC, durante 6 anos de follow-up.

Resultados: Dos 23 doentes que colocaram PPI, o IIEF5 pré-operatório indicou DE grave em 11 doentes (48%), moderada em 12 (52%). O IIEF5 pós-operatório revelou apenas 1 caso de DE ligeira (4%). Foram feitas 2 substituições de próteses por mau funcionamento e extração de 1 prótese por infecção.

No grupo dos 23 doentes com PPSR, o IIEF5 pré-operatório e pós operatório foi semelhante ao grupo anterior. 2 doentes queixaram-se de dor perineal (8%), 3 de encurtamento peniano (13%) e 3 de endurecimento excessivo peniano (13%).

Discussão/Conclusões: Tal como a nossa casuística demonstrou, existe evidência suficiente para recomendar esta abordagem em detrimento de outras menos invasivas, dado a sua alta eficácia, segurança e grau de satisfação.

P 26

USO DE TRAMADOL NA EJACULAÇÃO PREMATURA – REVISÃO BASEADA NA EVIDÊNCIA

Vasco Mota; Daniela Pereira; Diogo Ferreira; Filipa Matis; Maria João Ribeiro; Rosário Pires
USF Novo Sentido – ACES Porto Oriental

Introdução: A ejaculação prematura (EP) é a

disfunção sexual masculina mais frequente, afetando cerca de 20-30% dos homens. É uma situação que tem um importante impacto negativo na qualidade de vida do doente/casal, estando associada a altos níveis de ansiedade, depressão e dificuldade no relacionamento interpessoal. Deve, por isso, ser abordada oportunamente pelo médico de família, de forma a encontrar a melhor estratégia terapêutica. Têm sido realizados vários ensaios clínicos no sentido de avaliar a segurança e eficácia do tramadol no tratamento da EP, em alternativa aos inibidores seletivos da recaptação da serotonina (ISRS).

Objetivo: Rever a evidência disponível sobre a eficácia do uso de tramadol em homens com EP.

Metodologia: Foi efetuada uma pesquisa de meta-análises (MA), revisões sistemáticas (RS), ensaios clínicos controlados e aleatorizados (ECA), normas de orientação clínica (NOC) e guidelines, publicados nos últimos 10 anos, em português, inglês ou espanhol, na Pubmed, The Cochrane Library, DARE, NICE, Bandolier, TRIP, Clinical Queries e National Guideline Clearinghouse, utilizando os termos MeSH "tramadol" e "premature ejaculation". Para avaliação da qualidade dos estudos e força de recomendação foram utlizadas as escalas *Strength of Recommendation Taxonomy da American Family Physician* (SORT). Para avaliar a qualidade das guidelines obtidas foi usada a Appraisal of Guidelines for Research & Evaluation II (AGREE II).

Resultados: Da pesquisa realizada obtiveram-se 160 artigos. Destes, 9 preencheram os critérios de inclusão: 5 MA, 2 RS e 2 guidelines. Os restantes foram excluídos por divergência dos objetivos, por não cumprirem os critérios de inclusão, por serem repetidos ou por estarem incluídos em outros estudos (oito ECA). Uma guideline foi excluída após aplicação do AGREE II por conflitos de interesse evidentes. Foi atribuído um Nível de Evidência (NE) 2, às 5 MA e 2 RS analisadas. À guideline utilizada no estudo foi atribuído uma Força de Recomendação B.

Conclusão: A evidência analisada foi concordante em todos os artigos. O uso de tramadol antes da relação sexual mostrou aumentar o tempo de latência de ejaculação intravaginal (IELT) de forma estatisticamente significativa quando comparado com placebo ou com terapia comportamental. Revelou também não ser inferior à dapoxetina (tratamento de primeira linha). Devido à qualidade dos artigos analisados, os autores atribuem ao uso desta substância na EP, um grau de recomendação (GR) B.

P 27
IMPLANTAÇÃO DE PRÓTESES PENIANAS: A NOSSA EXPERIÊNCIA ACUMULADA

João Carvalho; Pedro Nunes; Hugo Antunes; Belmiro Parada; Vera Marques; Edgar Tavares-da-Silva; Francisco Rolo; Arnaldo Figueiredo
Centro Hospitalar e Universitário de Coimbra

Introdução: A prótese peniana (PP) é considerada terapêutica padrão na disfunção eréctil (DE) refratária à terapêutica médica. As complicações têm diminuído ao longo do tempo, tornando-a altamente satisfatória.

Objetivos: O objetivo deste estudo é avaliar os nossos resultados e o grau de satisfação.

Material e métodos: Realizou-se um estudo retrospectivo onde foram avaliados 42 doentes submetidos a colocação de PP entre novembro de 2000 e julho de 2017. Os dados foram obtidos a partir de registos médicos e entrevistas telefónicas: Analisou-se gravidade e etiologia da DE, o tipo de PP, complicações cirúrgicas, necessidade de reintervenção e satisfação.

Resultados: Cerca de 95% apresentavam inicialmente DE grave e a idade média aquando da implantação da PP foi de 54.3 ± 10.7 anos. A etiologia foi: vasculogénica (40.5%), multifactorial (26.2%), neurogénica (16.7%) e pós-prostatectomia radical (11.9%). Cerca de 42.9% padeciam de Diabetes Mellitus tipo 2 e hipertensão arterial simultaneamente,12.8% doença de La Peyronie e 19% eram transplantados: Renal,cardíaco ou hepático. O tempo médio de evolução da disfunção eréctil antes da colocação da PP foi

de 69.3 ± 10.9 meses. A maioria dos dispositivos era insuflável (72%). Não houve complicações em 76.2%:9.5% apresentaram disfunção mecânica, 9.5% apresentaram infecção e 4.8% erosão. A taxa de reintervenção foi de 26.2% e estes doentes foram submetidos a cerca de 2.3±1.8 intervenções. Verificou-se uma alta percentagem de satisfação (62%). Não houve qualquer relação entre comorbilidades e complicações. Não houve relação entre a etiologia ou o tempo de DE e complicações ou satisfação.

Discussão/Conclusões: A colocação da PP é importante na qualidade de vida: A presença de comorbilidades não teve influência. Mais experiência é necessária para melhorar o nosso nível de satisfação.

P 28

PLICATURA NA DOENÇA DE PEYRONIE. RESULTADOS DE SATISFAÇÃO EM DOENTES SUBMETIDOS A DUAS DIFERENTES TÉCNICAS.

Passos P.; Versos R.; Preza-Fernandes J.; Grenha V.; Ramires R.
Hospital Senhora da Oliveira, Guimarães

Introdução: A doença de Peyronie (DP) é causada pela fibrose progressiva da túnica albugínea que origina uma curvatura do pénis quando ereto. Esta pode conduzir a incapacidade de manter relações sexuais por dificuldade de penetração.

Objetivo: Avaliação da satisfação dos doentes submetidos a plicatura peniana por Técnica de Nesbit (TN) ou Técnica de Lue "16-dot" (TL), no Hospital Senhora da Oliveira.

Métodos: Estudo retrospetivo/descritivo da população tratada cirurgicamente para a DP por dois métodos de plicatura, entre Janeiro de 2013 e Dezembro de 2017. A informação foi obtida por consulta do processo clínico eletrónico e contacto telefónico.

Resultados: Foram incluídos na análise 44 doentes com idade média de 59 anos. Em 23 casos foi realizada a TN e em 21 a TL. Das variáveis analisadas, observaram-se diferenças estatisticamente significativas entre as duas técnicas (p=0,002) apenas na "perda de sensibilidade", sendo esta superior na TL. Não se identificaram diferenças estatisticamente significativas na correção total de curvatura (p=0,118), encurtamento peniano (p=0,602), dificuldade no ato sexual por encurtamento peniano (p=0,272), dor de novo (p=0,144) e disfunção erétil de novo (p=0,907). Dos doentes submetidos à TN, 47,6% mostraram-se muito satisfeitos, 42,9% satisfeitos e 9,5% insatisfeitos. Em relação à TL, 52,2% dos doentes revelaram-se muito satisfeitos, 26,1% satisfeitos e 21,7% insatisfeitos. Não se verificaram diferenças estatisticamente significativas quanto aos graus de satisfação.

Conclusão: Ambas as técnicas cirúrgicas obtiveram bons resultados quanto ao grau de satisfação do doente. Destaca-se a diferença estatisticamente significativa na perda de sensibilidade, mais frequente com a TL.

P 29

A IMPORTÂNCIA DAS CRENÇAS DISFUNCIONAIS NO DIAGNÓSTICO DA DISFUNÇÃO ERÉTIL

Ana Dias-Amaral; André Marques-Pinto; Berta Ramos; Diogo Barbosa; Vítor Covelo; Márcia Mota
Clínica de Psiquiatria e Saúde Mental, Centro Hospitalar de São João Serviço de Urologia, Centro Hospitalar do Porto

Introdução: Classicamente, a disfunção erétil (DE) é distinguida entre psicogénica e orgânica e algumas características podem apontar para a etiologia mais provável. Porém, estes resultados não são universais.

Objetivos: Estudar se na população de homens com DE observados na Consulta de Sexologia do CHSJ existem características diferenciadoras entre os grupos DE orgânica versus psicogénica.

Métodos: Recolheram-se os dados de uma série de doentes com DE nos últimos 3 anos. A análise foi feita com recurso ao STATA13.1, utili-

zando modelos estatísticos uni- e multivariados com nível de significância de 0,05.

Resultados: 103 homens, com 52,6±10,8 anos. 48,5% (n=50) dos casos foram classificados como DE psicogénica, 35,0% (n=36) como orgânica e 16,5% (n=17) como mista. Dos fatores de risco cardiovasculares (FRCV) analisados, a presença de DM (p<0,01) e dislipidemia (p=0,02) tem maior associação com DE orgânica. A verbalização de crenças sexuais disfuncionais tem maior associação com DE psicogénica (p<0,01). A proporção de doentes com início agudo do sintoma não diferiu entre os dois grupos (p=0,38). Homens com DE psicogénica tendem a procurar ajuda mais rapidamente (p=0,04). Não há diferenças na eficácia da resposta aos PDE5i entre os grupos (p=0,5). A análise multivariada, ajustando para a presença de crenças, não revela diferenças na prevalência de FRCV entre os grupos.

Conclusão: As características clínicas não distinguem de forma clara a etiologia da DE. No nosso estudo, a presença de crenças sexuais disfuncionais é o fator preditivo mais importante para o diagnóstico de DE psicogénica e deve ser questionado independentemente das comorbilidades.

P 30

RESULTADOS DA CORPOROPLASTIA PENIANA EM REGIME DE AMBULATÓRIO NO TRATAMENTO CIRÚRGICO DA DOENÇA DE PEYRONIE

Daniela Pereira; Luís Costa; Alexandre Gromicho; Débora Araújo; Pedro Costa; Raquel Rodrigues
Centro Hospitalar Vila Nova de Gaia Espinho

Introdução: A doença de Peyronie (DP) é um distúrbio caraterizado pela presença de placas fibrosas que condicionam a curvatura do pénis durante a ereção.

A DP tem um impacto negativo importante na função sexual, imagem corporal e QoL do doente. As opções de tratamento para a DP descritas na literatura são amplamente diversas.

O tratamento cirurgico é indicado para doentes com curvaturas significativas e estáveis.

Métodos: No CHVNG/E entre 2014 e 2017 foram realizadas em ambulatório 54 cirurgias para correção da doença de Peyronie. As técnicas mais amplamente utilizadas foram a plicatura de Nesbit , seguido da plicatura de Essed-Shcroeder.

A avaliação pós operatória foi realizada dentro de 4 a 6 semanas.

Discussão: A média de idades foi de 61,98 anos. Os doentes foram avaliados em relação ao tempo de evolução da doença e grau de curvatura e incómodo.

À data da cirurgia a maioria dos doentes (74%) referia ter entre 6 a 12 meses de evolução e 63% das curvaturas foram classificadas como complexas.

A correção da curvatura foi completa em 75% dos casos.

As complicações descritas mais comuns foram o encurtamento peniano, disfunção erétil e alteração da sensibilidade peniana.

Conclusão: O tratamento da DP permanece um desafio, dada a sua etiologia desconhecida e eficácia não comprovada da maioria dos tratamentos descritos na literatura.

A plicatura cirúrgica permanece a técnica menos invasiva e mais utilizada, com melhor preservação da função erétil.

O encurtamento peniano e alteração da sensibilidade permanecem como obstáculos importantes à obtenção de um resultado satisfatório.

POSTERS

P 01

THE EFFECT OF AGE ON FERTILITY RATE IN PATIENTS WHO UNDERWENT MICROSURGICAL VARICOCELECTOMY

Mustafa Suat Bolat; Murat Gulsen; Ramazan Asci
Ondokuz Mayis University, Samsun, Turkey

Introduction: Varicocele is considered the most common surgically correctable cause of subfertility characterized by a progressive decrease in testicular function. Varicocelectomy is thought that improves testicular function or stops testicular deterioration. A debate is open whether varicocelectomy is effective in older men.

Goals: To investigate the impact of varicocelectomy on semen parameters and natural fertility (NF) rate at different age groups.

Material and methods: Medical records were reviewed including demographics, patient questionnaires, operative notes, charts, hormone and semen analysis of men underwent microsurgical varicocelectomy between 2010 and 2017. The patients were divided into three groups based on age at surgery, including 20 years, 21-to-30 years, and >30 years. Total motile sperm counts(TMSC) were classified as IVF(<5x106), IUI (5x106-to-9x106) and NF (>9x106) categories. Upgrade rates to upper-level of TMSC category and NF rates were recorded.

Results: A total of 299 men met the study criteria. The mean infertility durations were 21.6, 20.8 and 35.6 months in Group 1,2 and 3, respectively. The TMSCs and sperm morphology significantly improved in all groups. The higher postoperative NF was detected in Group 1 (46.3%) compared to Group 2 (33.7%) and Group 3 (33.7%)(p=0.03). The fertility categories were similarly improved in all groups (p>0.05). The highest TMSC upgrade was observed in Group 1 with Grade 3 varicocele (p=0.01). Serum testosterone levels slightly increased in all the groups (p>0.05).

Conclusion: Microsurgical varicocelectomy markedly increased the TMSC and NF rates in patients in the younger ages regardless of age. Our findings support the younger patients predominately benefited from surgery.

P 02

PEYRONIE DISEASE – SURGICAL TECHNIQUE WITH SELF-ADHESIVE IMPLANT PRESENTATION OF THE TECHNIQUE AND PRELIMINARY RESULTS

Alberto Silva; Ana Cebola; A. Pepe Cardoso
Hospital Prof. Doutor Fernando Fonseca E.P.E., Portugal

Introduction: Peyronie's disease (PD) is a rare disorder of unknown etiology with a prevalence of 0,4-9% in man. About 2:3 cases emerge between 55-60 years-old and it is more frequent in patients with erectil dysfunction and diabetes mellitus.

PD is characterized by sometimes easily palpable fibrous inelastic plaques in penis, painful erections, penile curvature with shortening of the penis and erection problems leading to difficult or impossible sexual relations.

The techniques of penis lengthening are indicated in curvatures over 60 degrees with incision or partial or total plaque excision from the concave side of penis. It usually requires a graft and intend to minimize the penis shortening or correct complex defects. The use of fibrinogen sealant matrix graft and human thrombin (colla-

gen) revealed excellent results with less surgery time (self-adhesive technique without suture) and a good hemostasis.

Objectives: To present and discuss the result of a 7 patients series with DP submitted to the surgery technique of lengthening (incision/plaque excision) with self-adhesive graft.

Material and methods: We present a case series of 7 patients diagnosed with PD submitted to penis lengthening with self-adhesive graft. Those interventions were between 1st june of 2017 and 30th march of 2018 and occurred in Hospital Fernando da Fonseca and Santo Antonio Clinic (CLISA-LUSÍADAS). The patients were men between 40 and 70 years-old.

The sexual function was assessed trough the International Index of Erectile Function (IIFE-5), validated for portuguese population. A penile ecodoppler was performed at each patient. The inclusion criteria are in Table 1:

Table 1 – Inclusion criteria

- Disease's stability/curvature >12M
- Curvature > 60 º
- IIFE-5 > 25
- Penile Ecodoppler (rigidity phase) normal value (PSV >30 cm/sec, EDV< 10 cm/sec , IR > 0,7

We describe the surgical technique for the penile lengthening with self-adhesive graft (Tachosyl) with plaque incision versus plaque excision. The post-operative monitoring period was between 1 and 3 months.

Results: We describe the surgical steps used in two patients, illustrating the 2 technical approaches for the penile lengthening with self-adhesive graft. The Table 2 summarizes some patient clinical characteristics, surgical details and post-operative outcomes.

Conclusion: The correct indication for surgery (disease stability, no erectile dysfunction and curvature with sexual impairment) is essential for the treatment efficacy, independent of the surgical technique (Incision versus partial or total excision of the fibrotic plaque). The technique is operator-dependent. The Tachosil graft seemed a reliable option, with a good cost/effective relation, excellent hemostasis, less surgery time and fewer infection risk. The patient satisfaction depends on the expectative so the previous education and detailed information is a key point. More retrospective and prospective studies are needed.

Bibliography: Chung E, Ralph D, Kagioglu A, Garaffa G, Shamsodini A, Bivalacqua T, Glina S, Hakim L, Sadeghi-Nejad H, Broderick G. Evidence-based management guidelines on Peyronie's dis- ease. J Sex Med. 2016;13(6):905–23.

Ralph DJ, Gonzalez-Cavadid N, Mirone V, Perovic S, Sohn M, Usta M, Levine L. The management of Peyronie's disease: evidence-based 2010 guidelines. J Sex Med. 2010;7(7): 2359–74.

Kadioglu A, Tefekli A, Erol B, Oktar T, Tunc M, Tellaloglu S. A retrospective review of 307 men with Peyronie's disease. J Urol. 2002;68:1075–9.

P 03

THE IMPORTANCE OF SEXUAL BELIEFS IN THE EVALUATION OF ERECTILE DYSFUNCTION

André Marques Pinto; Ana Dias Amaral; Márcia Mota
Serviço Urologia, Centro Hospitalar do Porto, pORTUGAL

Introduction: Erectile dysfunction (ED) is usually classified as either organic (OED) or psychogenic (PED). Some clinical and laboratorial clues may help distinguish both entities but are not pathognomonic.

Objectives: To assess all men evaluated at the Sexology Department at Centro Hospitalar São João, regarding clinical and laboratorial aspects.

Methods: Data collection of patients between 2014-2017. Statistical analysis was performed on STATA13.1, by means of uni- and multivariable models with a significance level of 0.05.

Results: 103 men, aged 52.6±10.8. 48.5% (n=50) were classified as PED, 35.0% (n=36) as OED, and 16.5% (n=17) as mixed. Regarding cardiovascular risk factors, only diabetes melli-

tus (p<0.01) e dyslipidaemia (p=0.02) showed significant association with OED. Dysfunctional sexual beliefs ('I'm incompetent', 'Why isn't it working') are associated with PED (p<0.01). The proportion of patients with sudden symptom onset did not differ between both groups (p=0.38). PED patients tend to seek differentiated help earlier (p=0.04). There are no differences between groups regarding the efficacy of PDE5i (p=0.5). In a multivariable analysis, adjusting for dysfunctional beliefs, there are no differences concerning the prevalence of cardiovascular factors.

Conclusion: Clinical aspects do not clearly distinguish PED from OED. Dysfunctional sexual beliefs are the most important predictive factors for diagnosing PED. Therefore, it should be assessed irrespective of comorbidities, to unveil occult PED.

P 04

OUTCOMES OF AMBULATORY CHIRURGICAL PLICATION IN THE TREATMENT OF PEYRONIE'S DISEASE

Daniela Pereira; Luís Costa; Alexandre Gromicho; Débora Araújo; Raquel Rodrigues; Pedro Costa
CHVNG/Espinho, Portugal

Introduction: Peyronie's Disease is a fibrosing condition of the penis resulting in plaque formation and penile deformity. It has a negative impact in the patient's sexual life, body image and QoL. There is a large spectrum of treatment options which efficacy as not yet been proven.

The chirurgical approach is the best option in patients with important and stable curvatures.

Methods: In the CHVNG/E, between 2014 and 2017, we performed 54 ambulatory surgeries in patients with PD. Post operatory evaluation was performed within 4 to 6 weeks.

Discussion: The patient's median age was of 62 years.

All patients where asked about de time of evolution, grade of curvature and discomfort. About 74% of patients referred between 6 a 12 months of disease evolution and 63% of the curvatures where classified as complex.

A total curvature correction was achieved in 75% of the patients.

The major identified complications where penile shortening and impaired sensibility.

Conclusion: There is no consensus concerning the etiology and optimal treatment of PD.

Penile plication surgery is the least invasive and most commonly performed surgical option.

Penile shortening and impaired sensibility remain as two important obstacles in the way of an optimal surgical result.

P 05

TACHOSIL® GRAFTING IN THE CORRECTION OF PEYRONIE´S DISEASE: INITIAL EXPERIENCE OF A CENTER

Francisco Fernandes; Pedro Baltazar; João Pina; Jorge Morales; Fernando Calais; Luís Campos Pinheiro
Centro Hospitalar de Lisboa Central, Portugal

Introduction: Peyronie´s disease is a cause of penile deformation in the adult patient interfering with sexual intercourse. Surgical correction with grafting is the gold standard for complex curvatures, curvatures > 60º and small penis

Goals: To describe our experience with TachoSil® grafting in the correction of Peyronie´s disease. Evaluate surgical complications and results.

Material and methods: Retrospective analysis of 4 patients submitted to corporoplasty with TachoSil® grafting. We evaluate the following clinical data: erectile function, penile sensitivity, penile length, patient satisfaction and residual curvature. Penile color doppler with normal values was made to all patients before the procedure.

Results: Mean patients age was 60.3 [56-63]. Surgery was made for patients with prominent dorsal curvature (Mean 80º [60-90]) interfering with sexual intercourse. Mean surgical time was 80 minutes. After surgery there was no significant change in mean penile length or sensitivity.

There was complete resolution of the curvature in 2 patients with the rest maintaining residual curvature without interference in sexual life. There were no complications in the post-operatory time.

Discussion/Conclusions: Peyronie´s disease surgical treatment with TachoSil® grafting is feasible and promising. It´s easy application allows a lower surgical time. Also, it seems to have an additional haemostatic effect compared with the more used grafts.

P 06

PENILE CANCER: 18-YEAR EXPERIENCE FROM A TERTIARY CENTER

Jorge Correia; Diogo Gil-Sousa; Miguel Silva-Ramos; Nuno Louro; José LaFuente de Carvalho; Avelino Fraga
Centro Hospitalar do Porto, Portugal

Introduction and Goals: Penile cancer (NP) accounts for <1% of male cancers. Its reduced incidence results in a low evidence for the best therapeutic approach. Here we report our results in the management of patients with PC.

Methods: Retrospective analysis of 63 patients with PC, treated between 2000 and 2017.

Results: Mean patient's age was 61,8±12,2 years [34-84]. 81,8% presented risk factors for PC (smoking 47,2%, STDs 34,0%, phimosis 37,7%).

Most patients presented a single (88,9%), vegetating lesion (55,4%) with an average diameter of 36,5±21,5mm. Most were located in the glans (39,3%), followed by penile shaft (23,2%). Palpable lymph nodes were reported in 42,3%. Squamous cell carcinoma was diagnosed in 98.3% of the cases. The main surgical intervention was partial penectomy (68,3%), followed by wide excision of the lesion (14,3%).

In terms of pathological staging, 9.1% had noninvasive disease (CIS/pTa), 27.3% pT1, 32.7% pT2, 29.1% pT3 and 1.8% pT4. Radical inguinal lymphadenectomy was performed in 31,6% of patients and pelvic lymphadenectomy in 12,3%. 27,0% had recurrence after surgical treatment, with a time interval of 6,0±3,9months [1-12].

There was a clinically association between greater diameter of the lesion and higher risk of recurrence (p=0,027), and between palpable lymph nodes and greater risk of N+ (p=0,004) and M+ (p=0,026). We register an overall mortality rate of 27,3%.

Conclusions: Our cohort shows aggressive characteristics, with a high percentage of lesions in penile shaft, ≥pT2 staging and nodal involvement. This factor was reflected in a high rate of radical surgical approaches and inguinal lymphadenectomy.

P 07

FEMALE 46, XY

Ema Santos[1,3]; Pedro Francisco Fernandes[1]; Kathleen Brazão[2]; Filipa Abreu Santos[2]; Alexandre Gromicho[1]; Jorge Lima Fernandes[1]; Duarte Saunders[1]; Artur Real[1]; João Faria Nunes[1]; Manuel Serrão[1]; Ferdinando Pereira[1]
[1]Department of Urology, Hospital Central do Funchal; [2]Department of Gynecology, Hospital Central do Funchal; [3]Department of Paediatric Surgery, Hospital Central do Funchal, Portugal

Introduction: Complete Androgen Insensitivity Syndrome (CAIS) is an X-linked recessive disease caused by mutation in the androgen receptor gene. It is a pathology of sexual development with an incidence of 1/20000-100000 live male births. It is characterized by the presence of female external genitalia in individuals 46, XY with undescended testis and absence of response to appropriate androgen levels. Primary amenorrhea is the typical presentation.

Case report: A 17-year-old girl, with no relevant past medical history, has been referred to the Department of Gynaecology for evaluation of primary amenorrhea. Phenotypically with normal breast development, few pubic hair and normal female external genitalia. The gynaecological examination revealed a blind vaginal pouch with no palpable uterus. No palpable inguinal mas-

ses. Laboratory evaluation revealed an elevated serum testosterone (9.43 ng/mL). Karyotype 46, XY. Pelvic MRI identified two structures compatible with gonads, one on the right of the bladder and the another one in front of the left Psoas muscle, and absence of Mullerian structures. We have performed a bilateral prophylactic gonadectomy by laparoscopic approach. Pathological examination has confirmed testis with immature tubules surrounded by Leydig cells without neoplasia. The patient has started hormonal replacement therapy with estradiol.

Conclusion: Although genetically 46, XY, individuals with CAIS are phenotypically female and, therefore, require psychological counselling. Female gender identity should be advised. Considering the elevated risk of malignant transformation of post-pubertal gonads, prophylactic orchidectomy with subsequent hormonal replacement is recommended to maintain secondary sexual characteristics and bone mineral density.

P 08

LONG TERM RESULTS AND LESSONS LEARNED FROM TWO PLICATION TECHNIQUES IN PEYRONIE'S DISEASE

Passos P.; Preza-Fernandes J.; Grenha V.; Versos R.; Ramires R.

Hospital Senhora da Oliveira, Guimarães, Portugal

Introduction: Peyronie's Disease (PD) is a disorder characterized by fibrotic plaques of the tunica albuginea of the penis. Symptoms like curvature of the penis, painful erection and penetration cause significant mental distress and low quality of life.

Goals: The aim of the study was to compare long-term results in our institution of two plication techniques, Lue's sixteen-dot technique and Nesbit technique, in patients with PD.

Material and methods: Retrospective study of 44 patients treated for PD, with two plication techniques from January 2013 to December 2017. The information was obtained through the inspection of clinical records and interview with patients.

Results: The mean age of the patients was 59 years old. The Lue's technique was used in 21 patients and Nesbit technique in 23 patients.

Both techniques had very high sucess rates, with complete penile straightening verified in 85,7% with Lue's technique and 65,2% with Nesbit technique. Overall satisfaction was achieved in 90,5% of patients treated with Lue's technique and 78,3% of patients treated with Nesbit technique.

From the outcomes of both surgical techniques only the rates of sensory loss were significantly higher with Lue's technique (p=0,002).

No statistical differences between techniques was demonstrated in the difficulty of the sexual intercourse affected by penile sensory loss (p=0,949), shortening of the penis (p=0,602), de-novo erectile dysfunction (p=0,907) and de-novo pain during erection (p=0,144).

Conclusions: Overall both techniques were successful. Surgical method for the treatment of PD should be preferred based on surgeon's experience and patient's preference.

P 09

MALIGNANT BEHAVIOR LEYDIG CELL TUMOR – DESCRIPTION OF 2 RARE CASES

Débora Araújo[1]; Daniela Pereira[1]; Raquel Rodrigues[1]; Alexandre Gromicho[2]; Pedro Costa[1]; Jorge Dias[1]; Liliana Santos[1]; Xiaogang Wen[1]; Agostinho Sanches[1]; Luís Ferraz[1]

[1]CHVN Gaia/Espinho; [2]Hospital Central do Funchal, Portugal

Introduction: Leydig Cell Tumors (LCT) are rare neoplasms, accounting for about 1-3% of tumors of the testis; only 10% of these tumors are malignant. There are morpho-histological features suggestive of malignancy, however metastasis is the only definitive criterion.

Case 1: Male, 60-years-old, with a bulky left testicular mass. Multiple bilateral nodular testicular lesions were detected. An anatomopathological study after testicular biopsy revealed a LCT of

about 50 mm with features suggestive of malignancy. He died about 2 months after diagnosis with hepatic and bone metastasis. Hepatic biopsy was performed, which confirmed secondary involvement due to primary neoplasm of the testis.
Case 2: Young, 24-years-old, azoospermic, with complaints of right scrotal discomfort; the physical examination was normal. An image study detected right testicular nodule with about 8mm. After right radical orchidectomy, an anatomopathological study showed LCT with characteristics suggestive of malignancy. No diagnosis of metastatic disease to date.
Conclusion: The follow-up and therapeutic options of LCT, especially in relation to features suggestive of malignancy and / or proven metastatic disease, remain controversial. These neoplasms are chemo and radioresistant, conferring the malignancy a reserved prognosis.

P 10

RECURRENT PRIAPISM SECONDARY TO TRAZODONE – A RARE BUT IMPORTANT SECONDARY EFFECT

Débora Araújo[1]; Daniela Pereira[1]; Raquel Rodrigues[1]; Alexandre Gromicho[2]; Pedro Costa[1]; Jorge Dias[1]; Luís Ferraz[1]
[1]CHVN Gaia/Espinho; [2]Hospital Central do Funchal, Portugal

Introduction: Recurrent priapism is a variant of ischemic priapism characterized by prolonged and painful intermittent erections. These are urologic emergencies that can occur with irreversible sexual dysfunction and, in more severe cases, cavernous necrosis. About 30% of the cases are drug induced, and of these 80% are caused by trazodone. Trazodone is an atypical antidepressant widely used in clinical practice for its sedative and antidepressant properties. The incidence of priapism in patients taking trazodone is low and in most cases the therapy has been instituted for some time.
Clinical case: Caucasian male, 43-years-old, on trazodone 100mg in the last 18 months for terminal insomnia. He was sent to the external consultation of Urology because of new episodes of painful erections (average duration of 10 hours), which yielded only with intense physical effort with 6 months of evolution. No other relevant medical history, such as penile or perianal trauma, alcohol consumption and drug addiction. Unremarkable physical examination. Analytically without blood dyscrasias. The symptomatology disappeared with the suspension of the drug.
Conclusion: The relationship between trazodone and priapism is well documented. Even with the timely treatment of priapism, about 40-50% of patients may have permanent sexual dysfunction. Although severe, trazodone-induced priapism is a side effect rarely addressed and even underestimated in clinical practice. Given the increasing applicability of this drug, it is important to emphasize the importance of alerting these patients to this rare but significant side effect.

P 11

IS TESTICULAR SPERM EXTRACTION EFFECTIVE IN AZOOSPERMIC PATIENTS WITH PURE KLINEFELTER SYNDROME?

Débora Araújo[1]; Daniela Pereira[1]; Raquel Rodrigues[1]; Alexandre Gromicho[2]; Pedro Costa[1]; Jorge Dias[1]; Luís Ferraz[1]
[1]CHVN Gaia/Espinho; [2]Hospital Central do Funchal, Portugal

Introduction: Klinefelter syndrome (KS) is the most frequent chromosomic etiology of male infertility; characterized by the presence of a supernumerary X chromosome (47, XXY). Non-mosaic KS (NMKS) accounts for about 80-90% of KS cases. Prior to testicular sperm extraction (TESE), these patients were oriented toward reproductive techniques using donor sperm. Today, the success rate of sperm harvesting with TESE in these patients is around 50%, similar to non-obstructive azoospermia of normal karyotype.
Objective: To describe the experience of our center with TESE in NMKS.

Material and methods: A retrospective study was performed of all patients with azoospermic NMKS undergoing TESE in the Centro Hospitalar de Vila Nova de Gaia/Espinho from 1998 to 2015.
Results: 52 azoospermic NMKS were submitted to unilateral TESE (right testicle) under spermatic cord blocks. Sperm harvesting was successful in 21 of the cases, allowing a success rate of 40,3%, regardless of hormonal changes and age. No complications were identified. The fertilization rate was 38%, with a total of eight births. All babies were born healthy.
Discussion/Conclusion: TESE achieved good success rates for sperm retrieval and fertilization in patients with NMKS at our center, allowing us to offer the possibility of biological paternity to these patients rather than to resort immediately to donor sperm.

P 12
ZINNER'S SYNDROME – AN UNCOMMOM ETIOLOGY OF SCROTAL PAIN

Débora Araújo[1]; Daniela Pereira[1]; Raquel Rodrigues[1]; Alexandre Gromicho[2]; Pedro Costa[1]; Sofia Florim[1]; Jorge Dias[1]; Vitor Oliveira[1], Luís Ferraz[1]
[1]CHVN Gaia/Espinho; [2]Hospital Central do Funchal, Portugal

Introduction: Zinner syndrome (ZS) is a rare congenital malformation of the mesonephric duct that occurs in the first trimester of gestation; it is characterized by the triad: unilateral renal agenesis, cyst formations of the seminal vesicle and obstruction of the ipsilateral ejaculatory canal. Currently there are just 120 reported cases. They become symptomatic by the 2nd-3rd decade of life, clinically presenting nonspecific complaints such as discomfort / scrotal pain. In addition, they can be detected during the male infertility study.
Clinical case: Caucasian male, 21-years-old, healthy presented with 4-month history of intermittent scrotal pain. An enlarged right epididymis without inflammatory signs was observed. Echographically, right renal agenesis was diagnosed and a right pelvic nodular image was detected; pelvic magnetic resonance imaging (MRI) confirmed that this was a cystic dilation of the right seminal vesicle. In the MRI, dilatation of the right deferent canal was also observed throughout the trajectory, an aspect suggestive of obstruction of the ejaculatory canal; no ureter or right ureter meatus was visualized. The diagnosis of ZS was made. He performed a hormonal and spermogram study that was normal. It was decided to maintain conservative treatment with analgesia given the sporadic nature of the symptoms and absence of changes in fertility.
Conclusion: ZS is a difficult and often delayed diagnosis due to the lack of clinical specificity and the paucity of clinical cases. MRI sets the definitive diagnosis. The treatment should be conservative when asymptomatic or with mild symptoms, reserving the surgical treatment for the symptomatic cases.

P 13
PENILE PROSTHESIS IMPLANTATION: LAST 8-YEAR EXPERIENCE OF THE UROLOGY DEPARTMENT OF CENTRO HOSPITALAR LISBOA NORTE

Carolina Borges da Ponte; Ricardo Pereira e Silva; Sandro Gaspar; Anatolyi Sandul; Pedro Oliveira; Afonso Castro; João Gomes; José Palma dos Reis; Tomé Lopes
Urology Department of Centro Hospitalar Lisboa Norte, Portugal

Introduction: Penile prosthesis implantation constitutes a definitive treatment to restore sexual function in motivated patients with erectile dysfunction (ED) refractory to all other lines of treatment.
Goals: To evaluate indications, preoperative evaluation, patient satisfaction, surgical outcomes and post-operative complications.
Material and methods: Retrospective analysis and data collection were performed by reviewing all clinical records of patients implanted with any form of penile prosthesis from 2009

through 2017. Satisfaction was assessed by a phone call interview.

Results: 45 patients were evaluated; all prosthesis were placed by penoscrotal incision: 41 were the 3-piece inflatable and 4 malleable model. Mean age at the time of the procedure was 61,5 years old. Main etiology of ED was vascular (70%); other causes were post radical prostatectomy (13%), post anterior rectal resection (4%), post traumatic (2%) and the remain unknown. Mean hospital stay was 2 days and post-operative complications occurred in 15% of the cases: 5 patients presented with prosthesis infection, leading to surgical removal in 3 cases. Long-term functional results: 58% of the patients answered the satisfaction questionnaire; 74% of them presented a functional penile prosthesis and were highly satisfied.

Discussion/Conclusion: The main postoperative complication, although rare was penile prosthesis infection. Most of the patients were satisfied with the procedure, although two patients were unable to manage the device and one was proposed to surgical exploration for non-functional prosthesis. Penile prosthesis remains an important, viable and effective treatment for erectile dysfunction in case of refractory erectile dysfunction or intolerance to other lines of therapy.

P 14

INFERTILITY IS A RISK FACTOR FOR COUPLE'S SEXUAL FUNCTION

Athanasios Zachariou[1]; Fotios Dimitriadis[2]; Charalampos Mamoulakis[3]; Maria Filiponi[4]; Panagiota Tsounapi[5]; Andreas Karagiannis[1]; Ioannis Giannakis[1]; Pedro Lantin[6]; Marlon Martinez[1]; Athushi Takenaka[5]; Nikolaos Sofikitis[1]

[1]University of Ioannina, Medical School, Dept of Urology, Ioannina, Greece; [2]Aristotle University, Medical School, 1st Dept of Urology, Thessaloniki, Greece; [3]University of Crete, Medical School, Dept of Urology, Heraklion, Greece; [4]Physical Medicine and Rehabilitation Centre, Volos, Greece; [5]Tottori University, Medical School, Dept of Urology, Yonago, Japan; [6]Urology Centre of the Philippines, Manila, Philippines

Introduction: Sometimes couple's infertility is experienced as a crisis and a life failure. Sexual intercourse tends to lack emotional involvement and is limited mainly to fertile periods as it only aims at conceiving a baby.

Goals: Aim of the study was to evaluate the effect of infertility on sexual function of the infertile couple.

Materials and methods: 95 infertile couples (Infertility Group A) and 95 fertile couples (Control Group B) aged between 20 and 45 years were included in the study. None of them received treatment for IUI, IVF or ovulation induction. All participants were assessed with a short questionnaire concerning socio-demographic features (age, sex, education and occupation), the frequency of sexual intercourse and sex-life satisfaction using the Likert visual scale (1 to 5 points). Furthermore, women were assessed with FSFI-Gr to evaluate female sexual function. All men were assessed with IIEF-Gr to determine male sexual function. Statistical analysis was performed using Mann-Whitney U test and Chi-square test (Yates correction).

Results: Females from Infertility Group A had statistically significant lower scores in desire, arousal, orgasm and total FSFI score. Males from Infertility Group A had statistically significant lo-

wer scores in sexual desire and intercourse satisfaction. In addition, the frequency of intercourse and the sex-life satisfaction visual scale were statistically significant lower in Infertility Group.
Discussion/Conclusion: Infertility is a risk factor for couple's sexual function because it worsens both female and male sexual function.

P 15

COMPARISON OF ON-DEMAND USE OF PAROXETINE, DAPOXETINE, TADALAFIL AND DAPOXETINE WITH TADALAFIL IN TREATMENT OF PATIENTS WITH PREMATURE EJACULATION

Ahmet Tahra; Resul Sobay; Abdurrahman ínkaya; Ferhat Yakup Suçeken; Ugur Boylu; Eyup Veli Kucuk
Department of Urology, Health Sciences University, Umraniye Teaching Hospital, Istanbul, Turkey

Introduction: The main therapy for premature ejaculaiton is on demand dapoxetine and Selective serotonin reuptake inhibitors (SSRIs). Recently, it is stated that tadalafil therapy can be used in premature ejaculation.
Goals: The aim of the study was to compare the clinical efficacy and safety of the on-demand use of paroxetine, dapoxetine, tadalafil and dapoxetine with tadalafil in treatment of patients with premature ejaculation (PE).
Material and methods: In this retrospective study, 100 PE patients without erectile dysfunction (ED) were included during 2015-2016 from the chart review. Patients who took on demand paroxetine (20 mg), dapoxetine (30 mg), tadalafil (5 mg) and dapoxetine (30 mg) with tadalafil (5 mg) for 6 weeks were divided into five groups. All patients were evaluated with intravaginal ejaculatory latency time (IELT) and evaluated with Premature Ejaculation Diagnostic Tool (PEDT) and the patient satisfaction score before and after treatment.
Results: The mean of IELT, satisfaction score and PEDT in all groups was significantly improved after treatment. Dapoxetine with tadalafil group had the best values of IELT, satisfaction scores and PEDT in comparison with other treatment groups (p value <.001).
Conclusion: In conclusion, dapoxetine with tadalafil therapy is safe effective to improve PE patients without ED as compared to paroxetine, dapoxetine, tadalafil alone.

P 16

THE ROLE OF SERUM TESTOSTERONE, PROLACTIN AND GONADOTROPINS IN PATIENTS WITH PREMATURE EJACULATION

Ahmet Tahra; Resul Sobay; Ferhat Yakup Suçeken; Abdurrahman ínkaya; Eyup Veli Kucuk
Department of Urology, Health Sciences University; Umraniye Teaching Hospital, Istanbul, Turkey

Introduction: Premature ejaculation (PE) is one of the most common problem in men's sexual health. Hormones may directly or indirectly affect the ejaculatory control.
Goals: We aimed to investigate the role of serum testosterone, gonadotropins and prolactin in patients with PE.
Material and methods: In this retrospective study, 50 male patients with PE and 50 healthy men as controls were enrolled by the patients chart. Patients were evaluated by Premature Ejaculation Diagnostic Tool (PEDT) and intravaginal ejaculatory latency time (IELT). Patients with mean IELT values ≤60 s and PEDT total scores ≥11 were considered to have PE. Serum levels of total testosterone (TT), free testosterone (FT), follicle-stimulating hormone (FSH), luteinising hormone (LH) and prolactin (PL) were investigated in patients with PE and controls.
Results: There was no significant correlation between the sex hormones levels (TT, FT, FSH, LH and PL) and (age, body mass index (BMI), IELTS and total PEDT scores of the patients; p value >.05). There was no statistically significant difference between patients with PE and controls regarding the serum levels of TT, FT, FSH, LH and PL (p value >.05).
Conclusion: In this study we showed that there was no diffirence in serum levels of testostero-

ne, gonadotropins and prolactin in patients with PE and controls. In daily practice, it is not necessary that these hormones be routinely evaluated in PE patients.

P 17

SPERMATIC CORD TORSION IN THE ADULT PATIENT: REVIEW OF A CENTER

Francisco Fernandes; Hugo Pinheiro; Gil Falcão; Rui Bernardino; Thiago Guimarães; Vanessa Andrade; Fernando Calais; Luís Campos Pinheiro
Centro Hospitalar de Lisboa Central, Portugal

Introduction: Spermatic cord torsion (SCT) is a urological emergency that can lead to testicular loss if not treated on time. It is primarily a disease of adolescents and neonates, but around a third of the cases may occur in the adult.

Goals: To evaluate the clinical presentation of the adult patients (>18 years) submitted to scrotal surgical exploration (SE) with clinical suspicion of SCT and the possible factors that can contribute for the differential diagnosis.

Material and methods: Retrospective analysis of the clinical files of 92 patients submitted to SE with clinical suspicion of SCT between 01-2010 and 12-2017. The patients were divided in two groups according to the definitive diagnosis: 1 – SCT and 2 – other pathologies (infection, appendage torsion). We compared data from the history, physical examination, blood tests and color doppler.

Results: Group 1 included 70 patients (76%) and group 2 included 22 patients (24%). Group 2 had a higher mean age (26.9 [18-54] vs. 23.8 [18-62]). Between the compared clinical elements, we find significant difference according to the abnormal testis position, being more frequent in group 1 (66% vs. 36%). No significant difference was found according to pain duration, fever, scrotal erythema or oedema, pain on palpation and blood tests.

Testicular detorsion and preservation occurred in 71% of the patients.

Discussion/Conclusions: SCT is the most frequent cause of SE in the adult. Abnormal testicular position seems to be the most important sign in the clinical evaluation.

P 18

LOW-FLOW PRIAPISM AND POST-TREATMENT ERECTILE FUNCTION

Rui Bernardino; Luís Severo; Francisco Fernandes; Gil Falcão; Vanessa Andrade; Thiago Guimarães; Luís de Campos Pinheiro;
Centro Hospitalar de Lisboa Central, Portugal

Introduction: Priapism is an uncommon urological emergency that can lead to permanent impotence if medical intervention is not performed. There are three types: ischemic (low-flow-priapism) (LFP), no ischemic (high-flow), and recurrent ischemic (intermittent).

Goals: This study aimed to evaluate the efficacy of various treatment methods and the risk factors for erectile dysfunction (ED) in patients with LFP.

Material and methods: Between January 2010 and January 2018, 26 patients with priapism were treated in our department. Patient's history, clinical examination, blood tests and cavernous blood gases identified 21 patients with LFP. Erectile function after treatment was assessed using the the International Index of Erectile Function (IIEF-5) questionnaire.

Results: The causes of priapism were intracavernosal injection in 3 cases, idiopathic in 7 cases, haematological disorders and recreational drugs taking in 3 cases, and phosphodiesterase type 5 inhibitor in 5 patients. Eleven patients presented at more than 48 hours after the Priapism's onset. Corporal blood aspiration and intracavernous injection with sympathomimetic was initially performed in all patients. In 18 patients (17 of them with Priapism's onset more than 48 hours before), failure of conservative management imposed cavernoglandular shunts (6 Winter procedures and 12 Al-Ghorab procedures). In two cases a proximal shunt (Quackels) was performed by failure of the distal shunt. Eleven patients (52.3%) reported erectile

dysfunction after treatment. All patients in which cavernoglandular shunt was performed reported subsequent deterioration of the erectile function.
Discussion/Conclusions: Priapism requires prompt assessment and treatment. In patients with LFP, delayed presentation to the urologist and aggressive surgical interventions induce ED in almost all patients. Failure of rapid evaluation and treatment can result in significant morbidity.

P 19

THE EFFECTS OF BODY MASS INDEX ON SPERM PARAMETERS AND REPRODUCTIVE HORMONES IN MALES WITHOUT INFERTILITY RISK FACTORS

Baydilli, Numan; Akinsal, Emre Can.; Ekmekcioglu, Oguz.
Erciyes University Faculty of Medicine Urology Department

Introduction: Obesity can cause many health problems. It is thought that obesity may also be associated with male infertility
Goals: To investigate the relationship between body mass index(BMI) and sperm parameters, reproductive hormones in men
Material and methods: The charts of the males who attended our infertility clinic were investigated retrospectively. Cases with all risk factors affecting male infertility such as varicocele, undescended testis, epididymitis, mumps orchitis, testicular cancer, klinefelter syndrome, cystic fibrosis, immotile silia syndrome, vas agenesis, distal ejaculatory duct obstructions, translocation anomalies, hypogonadotropic hypogonadism, history of hydroselectomy, hernioraphy, orchiopexy, vasectomy and testicular sperm extraction were excluded. 1196 individuals, not carrying these risk factors except for BMI, were evaluated. They were identified as non-obese (BMI<25 kg/m2), overweight (BMI 25-29.9 kg/m2) and obese (BMI≥30 kg/m2) and categorized into three groups. Semen parameters such as sperm concentrations, total sperm counts, semen volumes, percentages of progressive motility, total progressive motile sperm counts and reproductive hormones such as LH,FSH, prolactin,estradiol,total testosterone, testosterone/estradiol ratio were evaluated in terms of BMI.
Results: No correlations between BMI and semen parameters were detected in groups. Total testosterone levels (p<0,001) and testosterone/estradiol ratios (p<0,001) were found significantly different.
Discussion/Conclusions: According to the results of our study, BMI affected reproductive hormones and did not affect semen parameters. But it is clear that the influence of reproductive hormones will also affect semen parameters. Further studies may reveal this potential relationship.

P 20

IMMOTILE CILIA SYNDROME – A RARE INFERTILITY CASE

Alexandre Gromicho; Pedro Costa; Raquel Rodrigues; Daniela Pereira; Débora Araújo; Vítor Oliveira; Luís Ferraz
Hospital Central do Funchal; Centro Hospitalar Vila Nova de Gaia e Espinho, Portugal

Introduction: Immotile Cilia Syndrome is a rare cause of infertility, where sperm motility is reduced or absent. Patients with this affection usually have a long history of chronic respiratory tract infections. The explanation for this is the lack of dynein arms of the axonem in the tail of the spermatozoa and in cilia present in the respiratory epithelium. About 50% of these patients also have situs inversus, a disease known as Kartagener's Syndrome.
Case report: 25-year-old man and his wife observed for primary infertility know for 4 years. The wife's gynecological examination revealed no abnormalities. A previous spermogram showed very low motility, with no abnormality in number, morphology or viability. A second spermogram confirmed this data. The patient didn't report a relevant medical history, only respiratory problems in childhood without current sequelae. He has a brother with a history of infertility and dextrocardia. The physical exa-

mination, hormonal study and chest X-ray were normal. Electronic microscopy showed that the heads of the spermatozoa presented intact nuclei and acromeron regions, however 85-90% of the flagella had no dynein arms.

Discussion and conclusion: Electronic microscopy should be considered in patients with very low mobility spermatozoa. ICSI can result in the birth of healthy children. However, there is the possibility of fertility and respiratory problems being transmitted to the newborns, so all couples should be informed of the risks.

P 21

ERECTILE REHABILITATION WITH INTRACAVERNOUS ALPROSTADIL AFTER RADICAL PROSTATECTOMY – THE IMPORTANCE OF A NURSING PROGRAM

Alexandre Gromicho; Pedro Costa; Raquel Rodrigues; Daniela Pereira; Débora Araújo; Jorge Dias; Rui Amorim; Paulo Espiridião; Luís Costa; Vítor Oliveira; Luís Xambre; Manuel Pereira; José Amaral; Luís Ferraz
Hospital Central do Funchal; Centro Hospitalar Vila Nova de Gaia e Espinho, Portugal

Introduction: Erectile dysfunction is one of the most frequent post-radical prostatectomy (RP) complications, having a great impact on patients' quality of life. Early treatment to promote sexual rehabilitation is associated with a high abandonment rate.

Aim: To evaluate the results of a sexual rehabilitation nursing program with alprostadil intracavernous injection (All) after RP.

Materials and methods: 120 patients were referenced for the sexual rehabilitation program between 2008 and 2016. In the first nursing consult, the process of preparation and administration of the All, as well as the possible complication associated with the treatment, are explained and a test is performed. In the following consults the teaching program is initiated, the nurse reviews information regarding the previous test and evaluates the patient's skills and autonomy in the preparation and administration of the drug.

Results: There were a total of 120 patients with an average age of 63,1 years. The majority of the patients assured they were sexually active prior to the surgery The nursing program was accepted by 109 patients and refused by 11 (9,2%). Of the 109 that accepted the program, 95 (87.2 %) successfully finished it. Complications were observed in 10% of the patients (with painful erection being the most frequent one), prompting refusal/withdrawal in 42% of patients.

Discussion and conclusion: Through this study it was assessed that of the 120 referenced patients, 95 (79.2%) acquired sufficient autonomy to prepare and administrate the medication at home, suggesting that a sexual rehabilitation program coordinated between doctors and nurses enables the achievement of high adherence rates.

P 22

LONG-TERM OUTCOMES OF THE PATIENTS UNDERWENT PENILE PROSTHESIS IMPLANTATION AFTER RADIAL FOREARM FREE FLAP NEOPHALLOPLASTY

Culha M.M.; Ciftci S.; Yuksekkaya M.; Uslubas A.K.; Kosem E.; Bosnali E.
Kocaeli University, Medical School, Urology Department, Kocaeli, Turkey

The aim of our study is to investigate the long-therm outcomes of the patients underwent inflatable three-piece penile prosthesis (IPP) implantation after radial forearm free flap neophalloplasty.

Between 2005-2017 three men and nine transgender patients who had radial forearm flap neophalloplasty surgery before, underwent IPP implantation in our department. Etiologies of these three mem were, bladder extrophy, penile necrosis due to infection and fire arm injury affecting the genital area. Median follow-up was 45 (range7 to 82) months. The records of these patients were reviewed and outcomes established.

Mean age was 25,2(range 21 to 39) years.

Mean time interval from neophalloplasty to IPP implantation was 19 (range 12-37) months. Three piece inflatable prosthesis was used for all patients. Mean surgical time was 155 (134-231) minutes. There was not any intraoperative complication. Penile prosthesis infection was determined in two transgender patients due to scrotal erosion of the pump in approximately three months after the surgery and underwent revision surgeries including reimplantation of the prosthesis. Penile prosthesis was reinfected in one of these two patients and explanted immediately. At the most recent follow-up eleven patients had functional devices and sexually active. The remaining patient is going to underwent scrotoplasty before IPP placement.

IPP surgery is complex and different for patients with neophallus. Surgery time is long and infection rate is high. Device erosion might be expected due to insufficient reconstructive surgery before.

P 23

SEXUAL DYSFUNCTION AFTER KIDNEY TRANSPLANT

Renato Lains Mota[1]; Rita Fonseca[1]; José Carlos Santos1; Domingos Machado[1]; Helder Monteiro[1]; Jorge Cardoso[2]

[1]Centro Hospitalar de Lisboa Ocidental; [2]Instituto Universitário Egas Moniz, Portugal

Sexuality is an important domain of the health-related quality of life (HRQoL) and of the global quality of QoL and is influenced by several biopsychossocial factors in the kidney transplant recipient. Sexual dysfunction aetiology after kidney transplant is presumed to be multifactorial. Sexual dysfunction exerts a negative impact on sexual satisfaction, HRQoL and global QoL.

This study purposes to evaluate male sexual function, sexual satisfaction and body image in a convenience sample of kidney recipients at Centro Hospitalar Lisboa Ocidental using the International Index of Erectile Satisfaction, the New Scale of Sexual Satisfaction, the Brief Symptom Inventory and the Body Image Scale. The response rate was 27.2% and erectile dysfunction was identified in 66.1% of the sample. A correlation was identified between sexual function and sexual satisfaction ($r=.598$; $p<.01$; $n=112$) and between body image satisfaction and sexual function ($r=-.193$; $p<.05$; $n=112$). The time after transplantation (< or >36meses) did not demonstrated a difference in sexual functioning or sexual satisfaction.

These results showed high sexual dysfunction rates in the sample compared to those exhibited by the general population. A relation between sexual function and sexual satisfaction was established although it is not possible to evaluate if it was already evident before kidney transplant. The greater satisfaction with body image was associated with better sexual function but not with sexual satisfaction. This probably evidences the adjustment mechanisms developed to maintain sexual satisfaction throughout the life. Longitudinal evaluation is still required for the effects that kidney transplantation exerts in sexuality.

P 24

SEXUAL DYSFUNCTION AND DISTRESS IN PREMENOPAUSAL WOMEN WITH MIGRAINE: ASSOCIATION WITH DEPRESSION, ANXIETY AND MIGRAINE RELATED DISABILITY

Faruk Kucukdurmaz[1]; Yılmaz Inanc2; Yusuf Inanc[3]; Sefa Resim[1]

[1]Kahramanmaras Sutcu Imam University, Department of Urology, Turkey; [2]Kahramanmaras Sutcu Imam University, Department of Neurology, Turkey; [3]Gaziantep University Department of Neurology, Turkey

Introduction: Migraine is a chronic disorder associated with impaired quality of life as well as sexual function. However, data about the sexual distress in women with migraine were lacked.

Goals: This study aimed to determine the incidence and associated risk factors of both sexual function and distress in premenopausal women with migraine.

Material-methods: Sixty-nine women diagnosed with migraine were included. Sexual function and distress were assessed by Female Sexual Function Index (FSFI) and Female Sexual Distress Scale-Revised (FSDS-R),respectively. Depression and anxiety were investigated by Hospital Depression and Anxiety Scale (HADS). Migraine related disability was evaluated by Migraine Disability Assessment Scale (MIDAS) and average severity of pain was determied by Visual Analog Scale (VAS).
Results: Fifty-five women reported to have sexual dysfunction. Any headache-related feature including MIDAS and VAS scores, depression or anxiety was found to be related with sexual dysfunction.sexual distress was noted in 37 cases and depression, VAS and MIDAS scores were significantly higher in women with sexual distress.
Conclusion: This study showed that women with migraine should be screened both for sexual dysfunction and distress to help clinicians dealing with sexual medicine to improve the standart of patient care in their regular practice. Special attention should be given to the ones whose MIDAS and VAS scores were high and who had depression.

P 25

EFFECT OF ENDOCRINE DISRUPTORS IN SPERMATOGONIAL STEM CELLS: WHERE DOES THE PROTECTIVE ROLE OF REGUCALCIN FIT IN?

Sara Correia[1]; Mariana Feijó[1]; João Ramalho-Santos[2]; Ans van Pelt[3]; Sílvia Socorro[1]
[1]CICS-UBI - Health Sciences Research Centre, University of Beira Interior, Portugal; [2]CNBC - Center for Neuroscience and Cell Biology, University of Coimbra, Portugal; [3]AMC - Academic Medical Center, Reproductive Biology Laboratory, Center for Reproductive Medicine, University of Amsterdam, The Netherlands

During the last decades, it has been shown that endocrine disruptors (EDs) exposure in utero and during early life can perturb hormonal signalling causing birth defects, behavioural disorders and disrupted spermatogenesis. All, modifications that can be passed down to the future generations. The spermatogonial stem cells (SSCs) are the basis of generating lifelong sperm that are responsible for the transmission of genetic information. However, little is known regarding the impact of EDs in this specific and crucial testicular cell type. Regucalcin (RGN) is a calcium-binding protein linked with male reproductive function by its protective role in the control of oxidative stress, cell proliferation, apoptosis and metabolism.
This study aimed to analyse the RGN's actions attenuating the effects of EDs in SSCs. For that purpose, SSCs transfected to overexpress RGN and cells with basal expression levels were treated with the xenoestrogen methoxychlor (MXC, 25 µM, 48 hours). Thereafter, the glycolytic activity and apoptosis rate were evaluated. The results obtained showed an increased glycolytic flux in the SSCs treated with MXC, an effect that was attenuated by RGN overexpression. RGN also counteracted the increased MXC-induced cell death. The present study, firstly showed that SSCs metabolism and apoptosis can be modulated by hormonal factors, and demonstrated that these cells are a direct target of EDs, namely MXC. Furthermore, RGN was identified as a protective factor against the noxious effects of EDs in SSCs and, consequently in male fertility.

P 26

HYPERESTROGENISM, GERM CELL APOPTOSIS AND MALE INFERTILITY: EXPLORING THE LINK

Sara Correia; José Eduardo Cavaco; Sílvia Socorro
CICS-UBI, Health Sciences Research Centre, University of Beira Interior, Portugal

The regulation of spermatogenesis is strictly dependent on the action of sex steroid hormones, which orchestrate the cellular and molecular events underlying germ cell development. Es-

trogens are important regulators of cell proliferation and apoptosis in a wide range of tissues. However, their effects in spermatogenesis have remained controversial, with independent reports arguing for the role of estrogens as survival factors and others as apoptosis-inducers. The literature review of clinical findings showed that estrogens concentrations are increased in the serum, spermatic vein, and intratesticular milieu of idiopathic infertile men, supporting a damaging role of these hormones for spermatogenesis. The present study investigated the effect of estrogens regulating apoptosis in the seminiferous tubules (SeT) and Sertoli-germ cell communication. Rat SeT were cultured in the presence or absence of 100 nM 17b-estradiol (E2), a concentration mimicking those found in the testis of infertile patients. E2-exposure deregulated expression of the stem cell factor (SCF, Sertoli cells) and its receptor c-kit (germ cells), a crucial system known to regulate germ cell survival and death. The altered expression of SCF/c-kit underpinned the increased apoptosis of germ cells, as evidenced by the increased ratio of proapoptotic/antiapoptotic proteins and augmented activity of apoptosis executioners proteins. Concomitantly, E2 decreased proliferation in the SeT determined by immunohistochemistry of the proliferation marker Ki67. In conclusion, high E2 concentrations unbalanced the SCF/c-kit system with impact on germ cell survival. These findings support the link between male idiopathic infertility and hyperestrogenism and provide a rationale for treatment approaches targeting estrogen-signaling mechanisms.

P 27

THE IMPACT OF LOW-INTENSITY SHOCK WAVE THERAPY ON ERECTILE DYSFUNCTION AND THE INFLUENCE OF DISEASE DURATION.

Pedro Simões de Oliveira; Tiago Ribeiro de Oliveira; Álvaro Nunes; Francisco Martins; Tomé Lopes
SCI Centro de Urologia, Lisbon, Portugal

Introduction: Erectile dysfunction (ED) is a common disease, nevertheless, none of the available treatments alter de underlying pathology. LiSWT may have the potential to cure ED and restore spontaneous erections.

Goals: To evaluate the impact of LiSWT on ED and the influence of disease duration on functional outcomes.

Material and methods: We prospectively analyzed patients who underwent LiSWT, from June 2016 to March 2018. Erectile function was assessed before and 6 weeks and 3 months after treatment with the International Index of Erectile Function (IIEF-5) and with penile doppler duplex ultrasound. Patients were divided into two groups accordingly to disease duration: £24 months (group 1) e >24 months (group 2).

Results: 25 patients were enrolled. Fifteen patients had arteriogenic ED, four arteriogenic and venous leak ED, three post-radical prostatectomy ED and three venous leak. In group 1 median IIEF-5 score before LiSWT was 15, at 6 weeks after LiSWT was 17 (p 0.008), at 3 months was 17 (p 0.012). Median peak systolic velocity (PSV) pre-LiSWT was 27.0 cm/s, post--LiSWT 30.1 cm/s (p 0.017). In group 2 median IIEF-5 score before LiSWT was 12.5, at 6 weeks after LiSWT was 15 (p 0.008), at 3 months was 18.5 (p 0.018). Median peak systolic velocity (PSV) pre-LiSWT was 28.5 cm/s, post-LiSWT 32.7 cm/s (p 0.016).

In group 1, IIEF-5 improvement at 6 weeks was 69.2%, in group 2 was 66.7% (p 1.00). At 3 months, improvement in group 1 was 61.5%, in group 2 was 83.3% (p 0.378).

In group 1, PSV improvement was 84.6%, in

group 2 was 83.3% (p 1.00).

Discussion/conclusions: LiSWT is a non-invasive therapy for ED, presenting good functional outcomes, and our results show that disease duration has no significant influence in treatment results.

P 28

THE EFFECT OF ARTIFICIAL URINARY SPHINCTER IMPLANTATION ON ERECTILE FUNCTIONS AND SEXUAL SATISFACTION

Ahmet Urkmez; Orhan Koca; Musab A. Kutluhan; Ramazan Topaktas; Mehmet Akyuz; Metin Ozturk
Haydarpasa Numune Research and Training Hospital, Department of Urology, Istanbul, Turkey

Objectives: Artificial urinary sphincter (AUS) implantation is the gold standard treatment in total urinary incontinence. Our aim in this study is to evaluate the effect of artificial urinary sphincter implantation on erectile functions and sexual satisfaction.

Material and methods: Fourteen patients aged between 58 and 73 years old who underwent artificial urinary sphincter implantation between May 2015 and December 2017 were included in our study. Patients with neurogenic disease, very low erectile functions (IIEF-5 score ≤ 10) or no erectile function and patients who underwent non nerve sparing radical prostatectomy was excluded from study. Erectile functions were evaluated preoperatively and postoperatively at six months of follow up by IIEF questionnaires.

Results: Mean age of patients was 66.92±4.51. Etiology of urinary incontinence was TUR-P in 2 patient, nerve sparing robot assisted radical prostatectomy in 3 patient and nerve sparing open radical prostatectomy in 9 patient. After AUS implantation; six patients were totally dry (no pad use and no symptoms), four achieved social continence (less than one pad/day), and four still had stress urinary incontinence (required two or more pads/day). Mean preoperative IIEF value of the patients was 16.14 ± 3.18 (12 to 22). Mean postoperative IIEF value was 17.42 ± 4.43 (8 to 26). Mean preoperative sexual satisfactory value was 8.57 ± 1.78 (5 to 11). Mean postoperative sexual satisfactory value was 8.71 ± 2.19 (5 to 11). There was no statistically significant difference between preoperative and postoperative IIEF and sexual satisfaction scores ($p>0.05$).

Conclusion: Artificial urinary sphincter implantation has no effect on patient's erectile functions and sexual satisfaction.

P 29

ULTRASONOGRAPHICALLY GUIDED PUNCTURE OF THE RETE TESTIS FOR TESTICULAR SPERM RECOVERY IN NON-OBSTRUCTED AZOOSPERMIC MEN

Fotios Dimitriadis[1]; Athanasios Zahariou[2]; Ioannis Giannakis[2]; Sotiris Skouros[2]; Panagiota Tsounapi[3]; Marlon Martinez[2]; Andreas Karagiannis[2]; Pedro Lantin[4]; Atsushi Takenaka[3]; Nikolaos Sofikitis[2]
[1]1st Urology Department, Aristotle University, School of Medicine, Thessaloniki, Greece; [2]Urology Department, Ioannina University, School of Medicine, Ioannina, Greece; [3]Urology Department, Tottori University, School of Medicine, Yonago, Japan; [4]Urology Center of the Philippines, Manila, Philippines

Introduction: Ultrasonographically guided puncture (UGUP) of the rete testis (RT) has been proven to be an efficient method for sperm recovery in obstructed azoospermic men (Andrologia 35:85, 2003).

Goals: In the current study, we evaluated the role of UGUP of the RT in sperm recovery from non-obstructed azoospermic (NOA) men.

Material and methods: Bilateral UGUP of the RT was performed in 99 NOA-men. Under local anesthesia and ultrasonographical control (mode B, frequency of 7.50 MHz), the hyperdense tip of a 30-gauge needle approached and reached the RT of each NOA-man. When ultrasonographical control demonstrated that the tip of the needle had reached the hyperdense line of the RT negative pressure was applied and cells from the RT were aspirated. All the aspirated samples from the RT were observed via

confocal scanning laser microscope (CSLM) and some of them after fluorescent in situ hybridization (FISH) techniques. Men who were negative for spermatozoa after UGUP of the RT underwent microsurgical therapeutic testicular biopsy (MTTB). Recovered spermatozoa subpopulations either from UGUP-RT samples or from MTTB-samples were frozen.

Results: UGUP of the RT resulted in sperm recovery in 19 men (19%). The remaining 80 NOA-men underwent MTTB. Twenty-nine men out of the 80 men (36%) who underwent MTTB demonstrated testicular spermatozoa. Thus in total, 48 men (48%) were positive for spermatozoa either in the UGUP-RT-samples or in the MTTB-samples. There was not a significant difference between the mean value of peripheral serum testosterone three months after UGUP-RT and the respective mean value prior to UGUP-RT. FISH techniques in UGUP-RT samples demonstrated in each of the 19 men at least 81% haploid spermatozoa. Hematomas were not demonstrated by ultrasonography one, three, and nine weeks post-UGUP-RT. Nine couples from the above mentioned 19 NOA-couples participated in assisted reproductive technology programs. Three clinical pregnancies were achieved. Four offspring were delivered.

Discussion/conclusions: Considering that UGUP-RT puncture a) does not reduce the volume of testicular parenchyma, b) is less invasive than MTTB, and c) apparently causes less detrimental effect on testicular vasculature than MTTB, UGUP-RT is recommended as first-line approach for the treatment of NOA-men. If UGUP-RT is negative for spermatozoa in non-obstructed men, biopsy is indicated.

P 30

VARICOCELECTOMY IMPROVES THE SPERM CAPACITY TO INDUCE OPTIMAL EMBRYONIC DEVELOPMENT POST-FERTILIZATION

F. Dimitriadis[1]; Y. Mio[2]; A. Karagiannis[3]; K. Margariti[3]; A. Kaltsas[3]; A. Paliouras[3]; A. Zachariou3; P. Lantin[4]; M. Martinez[3]; P. Tsounapi[5]; A. Takenaka[5]; N. Sofikitis[3]

[1]1st Urology Department, Aristotle University, School of Medicine, Thessaloniki, Greece; [2]MFC Clinic Yonago Japan; [3]Urology Department, Ioannina University, School of Medicine, Ioannina, Greece; [4]Urology Center of the Philippines, Manila, Philippines; [5]Urology Department, Tottori University, School of Medicine, Yonago, Japan

Introduction: Left varicocele has a detrimental effect (European Urology Supplements 13:89,2014) on the sperm ability to induce optimal early embryonic development (EED) post-fertilization.

Goals: Our objective was to evaluate the effects of varicocelectomy on the spermatozoal capacity to trigger early embryonic development of fertilized oocytes (recovered from female donors).

Material and methods: ICSI procedures using female donor oocytes were performed with spermatozoa from 13 men (group A) with left varicoceles after an observation period of six to 12 months. The female partners of the latter men could not produce oocytes of appropriate quality for participating in assisted reproductive technology (ART) programs. Injected donor oocytes were cultured for 96 hours. The fertilization rate (FR)(100Xfertilized oocytes/injected oocytes) and the blastocyst development rate (BDR)(100Xdeveloped blastocysts/fertilized oocytes) were recorded. Developed blastocysts were transferred to surrogate females. Another group of nine men with left varicoceles (group B) whose wives could not produce oocytes of appropriate quality for ART programs underwent microsurgical left varicocelectomy (MLV). Six to 12 months later ICSI cycles were performed using donor oocytes. FR and BDR were recorded, as well. Developed blastocysts were transferred to surrogate females.

Results: BDR was significantly larger (P<0.05) in group B (28.7%) than in group A (14.0%; Chi-Square test -Yates correction). In contrast differences in FR between groups B (82%) and A (83%) were not significantly different (P>0.05). Four (44%) and three (23%) pregnancies were achieved in groups B and A (P<0.05), respectively.
Discussion/Conclusions: MLV improves the ability of the male gametes to trigger the cascade of ooplasmic events that lead to EED up to the blastocyst stage. In the current study, the injected donor oocytes had been recovered from normal young females thus any female infertility factor is excluded. It appears that left varicocelectomy improves the DNA integrity, the male gamete nucleus protein matrix quality and/or the centrosomic integrity/function allowing more optimal EED. This study indicates an important role of the male gamete beyond fertilization. Such results have clinical significance in a surrogacy motherhood program whereby global legislation requires either of the intended parents to provide (in most cases the male partner) their own genetic material. Consequently, it is imperative to increase the quality of the sperm in order to achieve high pregnancy rates.

P 31

ROS (REACTIVE OXYGEN SPECIES) PRODUCTION BY THE SPERMATOZOA OF MEN WITH VARICOCELE: RELATIONSHIP WITH VARICOCELE GRADE

Ilter Alkan[1]; Erhan Ates[2]
[1]Department of Urology, Okmeydani Training and Research Hospital, Istanbul, Turkey; [2]Department of Urology, Adnan Menderes University School of Medicine, Aydin, Turkey

Goals: To investigate ROS (Reactive Oxygen species) production by the spermatozoa of men with varicocele and their relationship with varicocele grade and semen parameters.
Methods: This prospective study included 34 men with grade II-III varicocele, regardless of the fertility status. Control group consisted of 13 healthy men with normal semen analysis. Semen characteristics were examined according to the World Health Organization 2010 criteria. A swim-up method was used for sperm preparation. ROS production assayed by luminol-dependent CL (chemiluminescence) method. Results were given as RLU (relative light unit) /1.0 x 106 spermatozoa/mL. Log (ROS+1) of the results were used in calculations.
Results: Men with varicocele had significantly higher ROS levels than healthy control subjects (2.9 ± 0.4 RLU vs. 2.4 ± 0.1 RLU, p = 0.001) on luminol-dependent CL. Sperm concentrations and normal sperm morphology were significantly lower in varicocele group than control subjects (p<0.001). Varicocele grade III cases had significantly higher ROS levels than grade II cases and control subjects (p < 0.001). Varicocele grade III cases are associated with higher ROS levels and have lower sperm concentration and normal morphology than grade II cases. ROS levels were negatively correlated with all semen parameters.
Conclusions: ROS levels produced by spermatozoa are significantly increases in men with varicocele. ROS production is related to increased varicocele grade and impaired semen parameters in men with varicocele. ROS overproduction could be an important mechanism in the etiology of impaired sperm functions in varicocele.

P 32

EFFICACY OF ANTIOXIDANT TREATMENT ON SYMPTOMS OF PATIENTS WITH CHRONIC PROSTATITIS/CHRONIC PELVIC PAIN SYNDROME CATEGORY IIIA

Ilter Alkan[1]; Erhan Ates[2]
[1]Department of Urology, Okmeydani Training and Research Hospital, Istanbul, Turkey; [2]Department of Urology, Adnan Menderes University School of Medicine, Aydin, Turkey

Introduction: The etiology and underlying pathophysiological mechanisms of chronic prostatitis/chronic pelvic pain syndrome(CP/CPPS)

is still unclear. For these reasons, there is no standard treatment. Reactive oxygen species overproduction/decreased antioxidants has been shown in semen of CP/CPPS patients in these studies.

Goals: The aim of this study was to evaluate the effect of antioxidant treatment on symptoms in patients with CP/CPPS categoryIIIA.

Material and methods: We retrospectively evaluated the data of patients with chronic prostatitis/chronic pelvic pain syndrome category IIIA who treated by Progeny- M®, an antioxidant agent, between October 2016 and December 2017. The pretreatment and posttreatment symptoms were assessed using the National Institutes of Health-Chronic Prostatitis Symptom Index (NIH-CPSI). A reduction of the NIH-CPSI total score by ≥ 25% after the treatment was accepted as an improvement. A value of $P<0.05$ was considered statistically significant.

Results: Thirty-five out of 53 patients diagnosed with chronic prostatitis were CP/CPPS category IIIA. Seventeen of them were treated with antioxidant agent (Progeny- M®) for a month. Mean NIH-CPSI total score was significantly decreased after the treatment with Progeny-M® compared to pretreatment mean score ($p < 0.001$). Pretreatment mean pain, urinary and quality of life scores of NIH- CPSI (12.1 ± 3.8, 4.7 ± 2.8, 7.6 ± 2.7, respectively) were significantly decreased compared to posttreatment scores (8.2 ± 4.2, 3.1 ± 2.0, 5.2 ± 2.6) ($p < 0.001$, $p=0.002$, $p=0.004$, respectively).

Discussion/Conclusion: The mean total, pain, urinary and quality of life NIH-CPSI scores significantly decreased after 4 weeks Progeny-M® treatment in patients with CP/CPPS category IIIA. 58.8% patients had improvement NIH-CSPI scores after the treatment.

P 33

ARE THERE RELATIONSHIPS BETWEEN SEMINAL PARAMETERS AND THE NEUTROPHIL-TO-LYMPHOCYTE RATIO, THE PLATELET-TO-LYMPHOCYTE RATIO AND MONOCYTE-TO-EOSINOPHIL RATIO?

Faruk Küçükdurmaz; Neslihan Temiz Dogan; Caner Ölmez; Bekir Türkay Demir; Enes Baki Bilecan; Sefa Resim

Kahramanmaras Sutcu Imam University, Department of Urology

Introduction: Several hematological parameters are being investigated as useful prognostic markers based on host-related systemic inflammatory response. Although they are used to predict prognosis of patients in many conditions including various cancer types and inflammatory diseases; little is known about their prognostic efficacy in male infertility.

Goals: We aimed to evaluate the relationship of seminal parameters with the neutrophil-to-lymphocyte ratio (NLR), the platelet-to-lymphocyte ratio (PLR) and monocyte-to-eosinophil (MER) ratio, which are inflammatory markers, in men with normal and abnormal semen analyses. We also investigated the correlation between vitamin D levels and seminal parameters.

Material and methods: One hundred and twenty-six men with abnormal semen analyses and 79 men with normozoospermia were included in this study. A complete blood count was recorded, and the NLR, PLR, MER were calculated from the hematologic parameters. Vitamin D levels were also noted for participants.

Results: The NLR was 1.80 ± 0.65 in the normozoospermic group and 1.82 ± 0.66 in the abnormal semen analysis group. PLR was 104.28 ± 30.55 in the normozoospermic group and 106.73 ± 35.01 in the abnormal semen analysis group. MER was 2.99 ± 1.74 in normozoospermic men and 7.24 ± 16.57 in abnormal semen analysis group. No significant differences were found between the normozoospermic and the abnormal semen analysis group in the NLR ($p=0.911$), the

PLR (p=0.746) or MER (0.166).Vitamin D levels were also nonsignificant between two groups (37.62 ± 1.91 vs. 38.43 ± 2.51, p:0.103). In addition, no seminal parameters were correlated with the NLR, PLR or MER (p>0.05).

Conclusions: According to our results,it is not possible to recommend using the NLR, PLR or MER as markers to screen for abnormal semen parameters or male infertility.

P 34

PENILE PROSTHESES IMPLANTATION: OUR ACCUMULATED EXPERIENCE

João Carvalho; Pedro Nunes; Hugo Antunes; Belmiro Parada; Vera Marques; Francisco Rolo; Arnaldo Figueiredo

Urology and Renal Transplantation Department, Coimbra University Hospital Center, Portugal

Introduction: Penile prostheses (PP) are considered the gold-standard therapy for medically refractory erectile dysfunction (ED).

Goal: Evaluate outcome and patient satisfaction in our institution.

Material and methods: It was performed a retrospective observational study of 42 patients with erectile dysfunction who underwent implantation of PP, inflatable and semi-rigid, between November 2000 and July 2017.Data was obtained from medical records and telephone interviews.

Results: Nearly 95% had severe ED and were submitted to PP implantation at a mean age of 54.3±10.7[27-70] years.The main etiologies noticed were: arteriogenic (40.5%), multifactorial (26.2%), neurogenic (16.7%) and post-radical prostatectomy (11.9%). Diabetes mellitus type 2 plus arterial hypertension was founded in 42.9%, 12.8% had Peyronie disease and 19% were submitted to kidney or cardiac or liver transplantation. The mean time of erectile dysfunction evolution prior the PP implantation was 69.3±10.9 months. The majority of the devices were inflatable (72%).There were no complications noticed in 76.2%: 9.5% had a mechanical dysfunction, 9.5% infection and 4.8% impending erosion. Reintervention rate was 26.2% and those patients that were reintervented were submitted to nearly 2.3±1.8 interventions. There was a high percentage of satisfied and very satisfied patients (62%).There was no relationship between comorbidities and complications. There was no relationship between the etiology or time of ED and complications or satisfaction.

Discussion/Conclusion: The treatment of erectile dysfunction with PP maintains a positive impact on the quality of life.The comorbidities didn't have any impact in the outcome. More experience is needed to decrease our complication rate and to improve our level of satisfaction.

P 35

KLINEFELTER SYNDROME AND FERTILITY

João Carvalho; Belmiro Parada; Pedro Nunes; Hugo Antunes; Maria Freire; Luís Sousa; Eunice Matoso; Alexandra Estevinho; Ana Paula Sousa; Teresa Almeida Santos; Arnaldo Figueiredo

Urology and Renal Transplantation Department, Coimbra University Hospital Center; Medical Genetics and Reproduction Service, Coimbra University Hospital Center, Portugal

Introduction: Klinefelter syndrome is the most frequent sex chromosomal abnormality that causes progressive testicular deterioration and infertility.

Goals: Evaluate patients with Klinefelter syndrome and their fertility.

Material and methods: We performed a retrospective observational study of 24 patients with Klinefelter Syndrome followed at our institution since 2013 because of infertility. Statistical analysis was performed using SPSS Software 22, $p < 0.05$.

Results: At the first appointment, male age was 34.04 ± 5.2 years and woman age was 30.7 ± 5.0 years. 37.5% were smokers. The most frequent comorbidities were infectious (25%) and the presence of varicocele (20.8%). There were only 2 cases of mosaicism and 1 Y chromosome microdeletion. Only 2 patients were not azoospermic. Testicular biopsies were performed in

41.7%: Sertoli cell only syndrome and Leydig cell hyperplasia. All patients had hypergonatrophic hypogonadism, with LH of 16.8 ± 3.5 um/mL, FSH of 34.2 ± 12.7 um/mL and total testosterone of 2.5 ± 1.9 ng/mL.

No couple adopted children, five resorted to sperm bank, but only one had offspring. Two couples had children without need of MAP (medically assisted procreation) techniques, two had already had offspring from other relationships and seven are performing treatments. IVF was used in 77.8% and ICSI in 22.2%. There was no statistically significant relationship between testosterone and sperm volume and fertility.

Discussion/Conclusions: Klinefelter Syndrome patients are essentially azoospermic, have low testosterone values, and some can have offspring without MAP treatments.

P 36

LOW PRESCRIPTION OF PHOSPHODIESTERASE INHIBITORS FOR ERECTILE DYSFUNCTION TREATMENT BEFORE REFERRAL TO SPECIALIST CARE BY PORTUGUESE GENERAL PRACTITIONERS

Afonso Morgado[1,2]; Carlos Silva[1,3]
[1]Serviço de Urologia, Centro Hospitalar São João; [2]Departamento de Biomedicina, Faculdade de Medicina da Universidade do Porto; [3]Departamento de Cirurgia e Fisiologia, Faculdade de Medicina da Universidade do Porto, Portugal

Introduction: Erectile dysfunction is a prevalent disorder in Portugal with a study suggesting that 26.0% of Portuguese males over 60 years old complain about erection problems. However, only 15.5% of Portuguese General Practitioners (GP) actively ask theirs patients about sexual dysfunctions and 58.0% would refer to specialist care rather than treat a sexual dysfunction.

Goals: To assess how and why erectile dysfunction patients are referred by Portuguese GP for Urology care.

Material and methods: Three hundred consecutive male patients referred for erectile dysfunction for Urology care by GP were assessed after consent between January 2016 and December 2018. A full standardized medical and sexual history were taken. Previous medical treatment for erectile dysfunction, namely pharmacological name and dosages, as well as cardiovascular risk factors were noted.

Results: Only 33.8% of patients had already taken a phosphodiesterase 5 inhibitor and none had taken alprostadil by any route. Only 37.5% had been prescribed the highest dose PD5I. Sildenafil and avanafil were the most prescribed PD5I with 28.6% each. All these patients were referred for treatment failure. From the remaining untreated patients only 7.3% had three or more cardiovascular risk factors excluding gender requiring a stress test before treatment and only 7.8% needed referral to Cardiology according to the Princeton Consensus. Interestingly, 13.9% had actually premature ejaculation rather than erectile dysfunction.

Conclusions: Besides a significant misdiagnosis, there is an under treatment of patients with ED in Portugal at the primary health care level.

P 37

PROGNOSTIC VALUE OF PENILE DUPLEX ULTRASOUND IN ERECTILE DYSFUNCTION PATIENTS TREATED WITH SILDENAFIL: PRELIMINARY RESULTS

Afonso Morgado[1,2]; Carlos Silva[1,3]
[1]Serviço de Urologia, Centro Hospitalar São João; [2]Departamento de Biomedicina, Faculdade de Medicina da Universidade do Porto; [3]Departamento de Cirurgia e Fisiologia, Faculdade de Medicina da Universidade do Porto, Portugal

Introduction: Penile duplex ultrasound (PDU) has been used in the diagnosis of erectile dysfunction(ED) namely in the assessment of the vasculogenic component. However, its role in the prognosis of treatment is yet to be clarified.

Goals: To assess PDU value as a predictor of response to ED treatment with sildenafil.

Material and methods: Three hundred consecutive patients referred for ED by general practitioners were screened between January 2016 and December 2018 and those that were willing to participate were prospectively assessed with baseline, 3 and 6 months validated IIEF-5 and VAS. All patients had a standard penile duplex ultrasound with 20ug intracavernous alprostadil at baseline and started on demand treatment with sildenafil 100mg per protocol. Changes of treatment were allowed and recorded. Patients were divided in three PDU groups based on standard criteria EAU criteria. IIEF-5 and VAS were compared between normal and veno-oclusive dysfunction.
Results: There were 25, 18 and 5 patients with normal, veno-oclusive dysfunction and arterial insufficient respectively. Mean IIEF-5 score for normal and veno-oclusive dysfunction were 24.58±0.93 and 20.69±4.15 at 3 months and 25.00±0.00 and 22.18±3.06 at 6 months respectively. Final visit VAS score was 9.75±0.61 vs 7.91±1.45. There was a statistical difference at 3 and 6 months IIEF-5 score as well as VAS (p=0.006, p=0.012 and p=0.002 respectively).
Conclusions: PDU may have a role as a prognostic tool in ED treatment with sildenafil as a diagnosis of veno-oclusive dysfunction can predict worse response and satisfaction with treatment with sildenafil.

P 38

COST-EFFECTIVENESS OF SINGLE TOTAL TESTOSTERONE ASSESSMENT VERSUS COMPREHENSIVE HORMONAL EVALUATION IN PATIENTS REFERRED FOR ERECTILE DYSFUNCTION: PRELIMINARY RESULTS

Afonso Morgado[1,2]; Carlos Silva[1,3]
[1]Serviço de Urologia, Centro Hospitalar São João; [2]Departamento de Biomedicina, Faculdade de Medicina da Universidade do Porto; [3]Departamento de Cirurgia e Fisiologia, Faculdade de Medicina da Universidade do Porto, Portugal

Introduction: Current guidelines recommend total testosterone (TT) assessment in patients with erectile dysfunction(ED) to exclude hypogonadism, a prevalent co-morbidity. In case of a low TT, further LH, SHBG and albumin assessment is recommended. However, the need for recurrent venipuncture and extra appointment challenges the cost-effectiveness of the current stepwise approach in an high prevalence referral setting.
Goals: To assess cost-benefit of current step-wise approach versus initial comprehensive hormone assessment in the referral setting.
Material and methods: Fifty seven consecutive patients referred by general practitioners for ED were screened for hypogonadism in a step-wise approach with TT. If TT was inferior to 345ng/mL, LH and SHBG plus albumin were also assessed. The Portuguese Public Health Care Reimbursement tables was used to calculate associated direct costs with this step-wise approach and was compared with an initial hypothetic comprehensive hormonal evaluation for all patients.
Results: At baseline evaluation, TT was less than 345ng/mL in 33.3% patients (n=19 out of 57), prompting a comprehensive hormone assessment. Using the step-wise approach there was a direct cost saving of 0.51 € per patient. However, 1 out of every 3 patients had an extra venipuncture and an additional appointment. Indirect costs were not assessed.
Conclusions: Our study challenges the cost-effectiveness of the current recommendations. In fact, savings of 0.51 € per patient are greatly exceeded by other costs as the need for extra venipuncture and appointment in 1 out of every 3 patients as well as potential indirect cost such as patients lost time and productivity.

P 39

EDSEXU: EPIDEMIOLOGY OF SEXUAL DYSFUNCTIONS IN PORTUGUESE UNIVERSITY STUDENTS

Pedro Moreira; Bruno Jorge Pereira
Faculdade de Ciências da Saúde, Universidade da Beira Interior; Centro Hospitalar Cova da Beira, Portugal

Introduction: Sexual dysfunctions are well documented in the male and aging male. Conversely there's an unmet need in the epidemiological characterization of sexual dysfunctions in young adults. In these ages sexual dysfunctions are not uncommon and issues related to sexual function and its changes are also of concern.
Objective: To characterize the prevalence of sexual dysfunctions in Portuguese male university students. To check if there are differences between medical students and students from other areas.
Materials and methods: A questionnaire was developed and distributed by 9 higher education institutions. Results were analyzed using SPSS®.
Results: A total of 634 valid questionnaires were obtained. 34.7% of respondents said that they were "dissatisfied"/"very dissatisfied" with their sexual function. Medical students felt more fulfilled with their sexual function. 49.1% of the respondents consider that getting into university has impaired their sexual life/function. 4.3% and 11.9% reported some degree of difficulty in having or maintaining an erection, respectively. In at least half of sexual relationships, 18.2% reported ejaculation with very little stimulation and 24.1% before wanting. 2.4% reported an IELT of less than 1 minute, 6.3% between 1 and 3 minutes, and 7.1% greater than 30 minutes, resulting in an incidence of premature ejaculation of 8.7% and delayed ejaculation of 7.1%. It was verified a negative influence of alcohol consumption on the quality of erections and a higher IELT for smokers.
Conclusion: Sexual dysfunctions are not uncommon among Portuguese university students, with a large number of young people dissatisfied with their sexual function and/or life. There was better quality of sexual life, increased confidence in erectile function and overall sexual satisfaction for medical students when compared to students from other areas.

P 40

THE EFFECT OF MODIFIABLE LIFESTYLE FACTORS ON THE SEMEN QUALITY

Coskun KAYA[1]; Cem SENOL[2]; Murat TAS[1]; Aykut AYKAÇ[3], Yeliz Kaya[4]
[1]Eskisehir State Hospital; [2]Sincan State Hospital; [3]Karabük University School of Medicine, Department of Urology; [4]Eskisehir Osmangazi University Health Sciences Faculty Department of Nursing

Aim: To examine the association between lifestyle factors, (body mass index, smoking, alcohol consumption, coffee intake, physical activity, sauna and cell phone usage, wearing tight-fitting underwear), and conventional semen parameters.
Materials and methods: 1311 participants who attended the Andrology Clinic were included in the study. All participants were separated into two groups as men with normozoospermia and dysspermia. All participants answered a questionnaire which contains questions about the modifiable lifestyle factors. The total risk scores were calculated after all the positive lifestyle factors had been counted.
Results: Men with normozoospermia and dysspermia consisted of 852 (65.0 %) and 459 (35.0 %) participants respectively. A negative relationship between the wearing of tight underwear and having normal semen parameters was detected between the two groups ($p= 0.004$). While going to a sauna regularly was negatively related to semen concentration, wearing tight underwear was also related to both lower motility, normal morphology as well as semen concentration ($p<0.05$). While the total score of all participants was 5.22 ± 1.34 point, there were no statistical differences between the two groups ($p = 0.332$).

It was found that having 3 more or fewer points was not related to any type of semen parameters and results of a spermiogram.

Conclusion: The clinicians should give advice to infertile male patients about changing their risky lifestyle, for infertility, to a healthy lifestyle for fertility. Better designed studies, with larger sample sizes using conventional semen analysis with sperm DNA analysis methods, should be planned to identify the possible effects of lifestyle factors on semen quality.

P 41

FOOD WITH INFLUENCE IN THE SEXUAL AND REPRODUCTIVE HEALTH

Tânia Silva; Mariana Jesus; César Cagigal; Carla Silva
Centro Hospitalar e Universitário de Coimbra; CRI Psiquiatria e Saúde Mental, Portugal

Background: Sexual dysfunction and infertility are conditions with high prevalence in general population. Nutritional factors have been reported to have impact in sexual and reproductive health.

Objective: The aim of this review is to summarize the data on factors that have influence in male and female sexual and reproductive function including nutritional status, specific foods (e.g. dairy food), nutrients and other food components and dietary supplements.

Method: A literature search was performed using Cochrane Library, Medline and ScienceDirect databases without time limitations.

Results: Obesity has a negative influence in male fertility, and weight loss improves male fertility. Food insufficiency is associated with increased sexual risk behaviours, more relevant in women. Regarding to macronutrients and group foods, trans-fatty acids, high glycemic index food, high carbohydrate diet and soy isoflavones (for men), prejudices fertility; omega-3 and omega-6 fatty acids, vegetable proteins, antioxidants and full-fat milk improves fertility. Concerning to dietary supplements most of the products are lack evidence that sustains their efficacy and the most promising substances are yohimbine in erectile dysfunction patients, vitamin B in patients with hyperhomocysteinemia, L-arginine in patients with endothelial dysfunction nitric oxide related and vitamin D in patients with this deficiency.

Conclusion: The compiled results indicate that despite the multifactorial etiology of sexual/reproductive dysfunction, nutritional factors may affect the sexual and reproductive health in both men and women. However, it is necessary further studies to clarify this association, and simultaneously improve the approach and treatment of patients with sexual and/or reproductive problems.

P 42

ACTIVE MITOCHONDRIA, SEMINAL PARAMETERS AND CRYOPRESERVATION: HOW DO THEY CORRELATE?

Pinho, P.[1,2]; Arantes, R.[1,3]; Gomes, Z.[4]; Brito, M.[4]; Moutinho, O.[4]; Colaço, B.[3]; Pinto Leite, R.[1]
[1]Genetics/Andrology Laboratory, Hospital Center of Trás-os-Montes and Alto Douro (CHTMAD), Vila Real, Portugal; [2]Department of Genetics and Biotechnology, University of Trás-os-Montes and Alto Douro (UTAD), Vila Real, Portugal; [3]Centre for the Research and Technology of Agro-environmental and Biological Sciences (CITAB), University of Trás-os-Montes and Alto Douro (UTAD), Vila Real, Portugal; [4]Department of Obstetrics and Gynecology, Hospital Center of Trás-os-Montes and Alto Douro (CHTMAD), Vila Real, Portugal

Mitochondria are an important source of energy for spermatozoa necessary in both sperm motility and fertilization. To allow cell competence, plasma and mitochondrial membranes must remain intact. Several studies report that the proportion of functional sperm that retain intact mitochondrial activity, membranes and morphology after cryopreservation is low.

In this study, the influence of cryopreservation on mitochondrial activity, as well as on motility, vitality, morphology and concentration in 24 semen samples will be presented.

The semen analysis was conducted on fresh

samples and after 1 month cryopreserved. The percentage of spermatozoa with active mitochondria was also evaluated.

The seminal parameters were significantly worse ($p < 0.05$) after cryopreservation (concentration decreased from in fresh samples to after cryopreservation; vitality decreased from 77% to 28%; morphologically "normal" spermatozoa decreased 55%). Motility was the most affected parameter, decreasing 64% (from 71% to 26%), and in particularly the progressive motility (58% to 13%). Active mitochondria decreased by 59% (from 64% to 23%).

To our knowledge, few studies have compared mitochondrial activity with motility, vitality and morphology, before and after cryopreservation. In this work, the concentration was also analyzed and the results obtained are consistent with the literature. Despite the small number of samples, all semen parameters were worse after cryopreservation and a strong correlation between mitochondrial activity and motility was observed.

Cryopreservation is currently used for assisted reproduction. Concerning the implications of our results, it´s urgent to enhance efficiency of freezing system, testing other protocols with different cooling/thawing rates.

P 43

SHOULD WE RELY ON DOPPLER ULTRASOUND FOR EVALUATION OF TESTICULAR SOLID LESIONS?

Baris Esen; Muhiddin Önder Yaman; Sümer Baltacı
Ankara, Turkey Department of Urology, Medical Faculty, Ankara University,

Purpose: Colour Doppler ultrasound (CDUS) is the main radiologic tool to evaluate scrotal masses and intratesticular – vascularised solid lesions are mostly considered malign lesions. Objective of this trial is determine ratio of benign lesions in patients with hypervascularised solid intratesticular lesions.

Material and method: Patients who underwent radical orchiectomy due to hypervascularised intratesticular solid lesions detected in CDUS are evaluated retrospectively. Those with previous testicular cancer history and inguinal/scrotal surgeries were excluded from the study. All patients are evaluated for age, preoperative testicular atrophy, multicentricity, echotexture and size of solid lesions, preoperative tumor markers (AFP, bHCG and LDH), and postoperative pathology results. Two tailedp value test was used to evaluate numeric parameters and Fisher's exact test was used to evaluate non-numeric parameters.

Results: A total of 117 patients with a mean age of 35.9 (5–86) were included to the study. Mean size of solid lesions was 4.39 cm. Seven patients had subcentimeter (subcm) lesions. 101 patients had hypoechoic, ten patients had isoechoic and six patients hyperechoic solid lesions. Preoperatively 60 patients (51.2%) had at least one tumor marker elevated. Postoperative pathology examination resulted to; 21 patients (17.9%) had benign lesions. Elevation of tumor markers, palpability, hypo- echoic texture and larger size of the solid lesion were found to be parameters that predict malignancy.

Conclusion: Benign incidence of vascular testicular solid lesions detected with scrotal ultrasound with colour Doppler is greater than expected. In patients with smaller, non-palpable lesions without elevated tumor markers, treatment options other than radical orchiectomy such as testicular sparing surgery should be considered.

P 44

IDIOPATHIC MALE INFERTILITY – COMPARATIVE STUDY OF THE EFFICACY OF EMPIRIC THERAPY WITH CLOMIPHENE WITH OR WITHOUT SPERMOX®

João Pimentel Torres; Ricardo M. Rodrigues; Sara Anacleto; Nuno Morais; Agostinho Cordeiro; António P. Carvalho; Estevão Lima
Hospital de Braga; Hospital Privado de Braga, Portugal

Objective: Determine the effect of empirical treatment with clomiphene (anti-oestrogen)

and/or Spermox® (antioxidant) in pregnancy rate and sperm parameters in men with idiopathic infertility.

Methods: We did a retrospective study of 36 patients receiving empiric therapy for idiopathic male infertility, of which 15 were treated with clomiphene 50mg id and 21 with clomiphene 50mg id plus Spermox ® 1 sachet id. We evaluated sperm parameters before and after 3 months of treatment. The pregnancy rate was also estimated.

Results: The observed pregnancy rate (53.7%) was above that of patients without medication (13.3%). There were no differences between the two types of medication (p=0.12). There was a significant increase in some sperm parameters: total count (p=0.008), total mobility (p=0.001), progressive mobility (p=0.003) and vitality (p=0017). A statistically significant decrease in the volume was observed (p=0.014), while the percentage of normal forms showed no significant differences (p=0.538). In addition, there were not found significant differences in the parameters of semen analyses by type of medication. The results of logistic regression showed that patients treated with clomiphene were 10 times more likely to became pregnant (OR=10.00, p<0.10) than patients taking the association with Spermox®.

Conclusions: Empirical therapy of idiopathic male infertility can significantly increase the rate of pregnancy and semen parameters. There were not significant differences in the parameters of sperm in the use of clomiphene alone or in combination with Spermox®. The results also suggest that the use of clomiphene alone is more likely to achieve pregnancy than the association.

P 45

SEXUAL DYSFUNCTION IN PATIENTS WITH RADICAL ONCOLOGIC SURGERY OF THE RECTUM

Alberto Silva[2]; David Aparício[1]; Carlos Leichsenring[1]; António Gomes[1]; Augusto Pepe Cardoso[2]; Francisco Carrasquinho[2]; Vasco Geraldes[1]; Vítor Nunes[1]
[1]Surgery Service, Hospital Professor Fernando da Fonseca; [2]Urology Service, Hospital Professor Fernando da Fonseca, Portugal

Introduction/Objectives: Treatment of rectal neoplasia includes complete excision of the mesorect with or without chemoradiotherapy (QRT). This approach is associated with genito-urinary complications (11-76%) with significant repercussions on patients' quality of life.

Material/Methods: Retrospective study (1-1-2015 to 31-7-2017), Inclusion if: male, age > 18yrs and ≤75yrs, elective radical oncologic rectal surgery (CEROR); Exclusion if: prior pelvic radical surgery, previous severe sexual dysfunction (SD), Chronic urinary catheterization.

Outcome: SD vs Variables: tumor location (medium-low rectum (RMB) Vs High rectum); type of surgery (total mesorectum excision (TME), partial mesorectum excision (PME), abdomino-perineal amputation (AAP)); Approach (Lap Vs open); Complications; stoma; anatomopathological criteria; QRT.

Application of questionnaires: IIEF, BIPQ and IPQ after diagnosis, after CEROR and after reestablishment of intestinal transit. Statistical significance: p <0.05

Results: N = 42 (55% participation). 70% RMB tumors (p = 0.26). 30% PME; 48% TME; 22% AAP (p = 0.32). 22% by VL (p = 0.18). 78% with stoma after CEROR (p = 0.18). 96% complete or nearly complete mesorecto. 91% R0 resections. 43% with T> 2 (p = 0.73). 21% need for surgical reintervention (p = 0.39). 49% underwent neoadjuvant CRT (p = 0.38). 65% of patients have DS: 57% if absence of stoma, 70% with stoma; 75% if tumor of RMB and 50% if rectum high.

Discussion/Conclusion: Most patients who

undergo CEROR have DS. No relationship was found between DS and tumor location, type of surgery, approach, T, surgical reintervention and neoadjuvant QRT.

P 46

T-SHUNT + INTRACAVERNOSAL TUNNELING IN PATIENTS WITH REFRACTORY ISCHEMIC PRIAPISM

Murat Çakan; Fatih Sandıkçı; Mehmet Çaglar Çakıcı; İbrahim Güven Kartal; Alihan Kokurcan
Health Science University, Diskapi Yildirim Beyazit Health Practice and Research Center

Aim: In this study, three patients' dates who had undergone T-shunt + tunneling operation in our clinic were examined.
Material/Method: Between August 2015 and March 2018, T-shunt + tunneling were performed in 3 patients with refractory ischemic priapism to our clinic. The duration of priapism was 4 days, 7 days and 3 days respectively in these patients. The patients had previously failed unsuccessful distal shunt procedures. Etiology was the use of coumadin, vacuum device and antidepressant + antihypertensive drugs respectively.
Results: After T-shunt + tunneling, resolution was provided in all of the patients. There was severe fibrosis in the right corpus cavernosum in patient with 7 days of priapism, while all patients had moderate cavernous fibrosis. This patient had a slight urethral injury at the end of tunneling the right corpus cavernosum and a 14 f foley urethral catheter was gently placed. No other complications occurred in per-operative and early post-operative period. All patients were discharged within 2-3 days after surgery.
Conclusion: T-shunt + tunneling surgery is an effective treatment method for patients with refractory priapism even in 7 days duration. However, tunneling application should be performed with the caution.

P 47

EARLY SURGICAL REPAIR OF PENILE FRACTURE WITH AND WITHOUT URETHRAL INJURY

Nusret Can Cilesiz; Arif Özkan; Arif Kalkanlı; Mustafa Bahadır Can Balcı; Aydın İsmet Hazar; Cem Tugrul Gezmis; Gökhan Yazıcı; Taha Göv; Memduh Aydın
Gop Taksim Education and Research Hospital

Objective: Penile fracture is a rupture in corpus cavernosum resulting from dissociation in tunica albugine. Penile fracture usually occurs after severe sexual intercourse. About 10–20% of patients with penile fracture have urethral injury. Imaging methods include penile Doppler ultrasound (USG), pelvic MRI (magnetic resonance imaging), and retrograde urethrography for urethral evaluation. In this study, we aimed to present our clinical approach to patients with penile fracture and especially what should be considered in the diagnosis and treatment of urethral injured penile fractures.
Material and methods: We retrospectively reviewed the data of 71 patients treated with penile fracture diagnosis between October 2006-May 2015. Four patients developed during manual penile flexion, the remaining 67 patients (94%) developed during sexual intercourse. Twelve (17%) patients with urethral injury were all during sexual intercourse. For definite diagnosis, all patients had penile USG, and retrograde urethrography was performed for urethrorrhagia. Surgical repair was performed in all patients. Absorbable 2/0 and 4/0 sutures (polyglycolic acid) were used for the repair of tunica and urethra.
Results: Six patients (8%) reported mild curvature that did not interfere with sexual intercourse. The mean IIEF score of the patients was found to be 24.7 (24–30). Only 1 patient had moderate erectile dysfunction. Mild degree of arterial insufficiency was detected in penile Doppler USG of this patient. Six patients (8%) had a painful erection for two months after surgery.

There were plaques in 2 patients (3%). Mild LUTS was detected in 3 patients. Mean Qmax was 27.7; Residual urine was monitored physiologically.

Conclusion: As a result, penile fracture is usually an urgent urological condition due to sexual intercourse. Early surgical repair significantly reduces long term complications. Penile fracture patients should be evaluated well for urethral injury. Urethral injury should be investigated by performing preoperative retrograde urethrography in patients with bilateral corpus cavernosum damage, urethrorrhagia, and macroscopic hematuria

P 48

THE EFFECT OF INTRAVESICAL BOTOX TREATMENT ON FEMALE SEXUAL DYSFUNCTION IN OAB PATIENTS

Nusret Can Cilesiz; Aydın ísmet Hazar; M.B. Can Balcı; Arif Kalkanlı; Arif Özkan; Cem Tugrul Gezmis; Gökhan Yazıcı; Taha Göv; Memduh Aydın
GOP Taksim Education and Research Hospital

Introduction: Overactive bladder (OAB) clinic has been shown to cause sexually dysfunction in women with anatomical psychological and neurobiological origin. In this study, we aimed to present the effect of intravesical onabotulınumtoxinA treatment on the postoperative sexual function of patients with OAB.

Material and method: Between April 2017 and February 2018, patients with a stable sexual partner were included in the study. Patients with idiopathic OAB (≥8 times urinary frequency ≥ 1 urgency incontinence) were included in the study. Patients whose symptoms did not diminish despite at least 2 different anticholinergic treatments and patients who developed adverse side effects were included in the study. Urinary tract infection, malignancy, urinary tract stones, stress urinary incontinence, post-void residual (PVR) ≥100 cc, stage ≥2 pelvic organ prolapse were defined as exclusion criteria. ntravesical onabotulınumtoxinA (100 U, Allergan, Westport, County Mayo, Ireland) was diluated with 10 cc isotonic and injected to 20 points of bladder (0.5 cc each other) by 23G needle from 19 ch cystoscope. OABV-8, ICIQ-SF and FSFI questionnaire forms were filled before injection and postoperative 12th week.

Results: Thirty-five patients completed follow-up visits throughout the 12th week. The mean OABV-8 (23,4 ± 2,1 / 16,8 ± 1,6) (p = 0.028) was significantly higher in the patients before and after the intravesical onabotulınumtoxinA injection. The mean ICIQ-SF (16,4 ± 1,4 / 6,8 ± 0,7) (p = 0.009) and FSFI (19,8 ± 1,4 / 23,1 ± 1,1) (p = 0.018) showed statistically significant improvement. According to the mean values of sexual function in the subgroups, postoperative sexual desire (2.8 ± 0.4 vs 3.3 ± 0.3)(p=0.034), arousal (3.1 ± 0.5 vs. 3.6 ± 0.7)(p=0.026), orgasm (2 ± 0,6 vs 4,1 ± 0,6)(p=0.031), satisfaction (2,8 ± 0,5 vs 3,5 ± 0,8)(p=0.018) and pain (3,7 ± 0,8 vs 4,1 ± 0,7) (p=0.026) scores were statistically significantly improved (p <0.05). There was no statistically significant difference in the lubrication scale (4,3 ± 0,6 vs 4,5 ± 0,7) (p> 0.05).

Conclusion: It has been shown that intravesical onabotulınumtoxinA treatment improves symptoms of overactive bladder as well as improves the sexual function.

PLATINUM SPONSOR

JABA RECORDATI GROUP

GOLD SPONSORS

A. MENARINI PORTUGAL

Boston Scientific
Advancing science for life™

Coloplast

Dornier MedTech

Lilly

med4you
medical devices

SILVER SPONSOR

BTL 25 YEARS

Organização

SPA
SOCIEDADE PORTUGUESA
DE ANDROLOGIA, MEDICINA SEXUAL E REPRODUÇÃO

ASESA
ASOCIACIÓN ESPAÑOLA DE ANDROLOGÍA,
MEDICINA SEXUAL Y REPRODUCTIVA

esau eau

Patrocínios Científicos

Associação
Portuguesa
de Urologia

DGS desde 1899
Direção-Geral da Saúde

European Society for Sexual Medicine
ESSM

ORDEM DOS MÉDICOS

SOCIEDADE PORTUGUESA
DE SEXOLOGIA CLÍNICA

Secretariado

admédic+
ORGANIZAÇÃO E SECRETARIADO
DE EVENTOS

Calçada de Arroios, 16 C, Sala 3 1000-027 Lisboa
T: +351 21 842 97 10
F: +351 21 842 97 19
E: ana.pais@admedic.pt
W: www.admedic.pt

Agência de Viagens Oficial

admédic+ Tours

Calçada de Arroios, 16 C, Sala 3
1000-027 Lisboa
T: +351 21 841 89 50
F: +351 21 841 89 59
E: paula.cordeiro@admedictours.pt
W: www.admedictours.pt RNAVT 2526