

PD44-11**AN ARGUMENT FOR PRE-OPERATIVE PELVIC IMAGING PRIOR TO SECONDARY PENILE PROSTHESIS SURGERY**

Joseph M Caputo*, Christopher I Sayegh, Shyam Sukumar, Denise Asafu-Adjei, Doron S Stember, Peter J Stahl, New York, NY

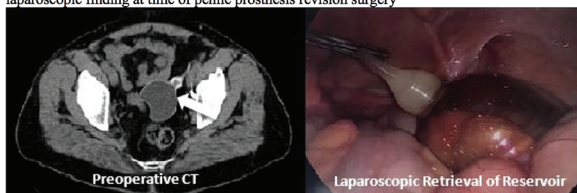
INTRODUCTION AND OBJECTIVES: The risks of secondary penile prosthesis (PP) surgery (revision, replacement or explant) include catastrophic complications such as visceral organ injury, vascular injury, and failure to remove a PP component. Preoperative imaging is a potentially useful strategy to mitigate risk and facilitate surgical planning. Our objective was to evaluate the potential clinical utility of CT imaging prior to secondary PP surgery.

METHODS: CPT codes and retrospective chart review was used to identify 84 men who underwent CT at our center after primary PP surgery from 2003-2018 (including men who underwent primary surgery at our center and men who had primary surgery outside). CTs were reviewed by a fellowship-trained prosthetic urologist for PP component locations, distances from the reservoir to the nearest iliac vessel, and presence of rear tip extenders (RTEs) in the proximal crura (using CT bone window). Findings were compared with available op notes.

RESULTS: Atypical reservoir locations were found in 8/84 (9.5%) men. 5 reservoirs were intraperitoneal, 2 were subcutaneous, and 1 was in the thigh adjacent to the femoral vessels. Primary PP surgery op notes were available for 76 men. Reservoir locations were discordant from the op note in 15/76 (20%), including 8 reservoirs on the opposite side and 7 in a different anatomic compartment. Median distance from the reservoir to the nearest iliac vessel was 0.23 cm (IQR= 0-0.87). The reservoir was in direct contact with an iliac vessel in 28/84 (33%) men, and in direct contact with the bladder in 47/84 (56%) men. The proximal crura of the penis were evaluable on 69/84 CTs, which allowed for identification of 6/69 (9%) suspected proximal perforations and 4/19 (21%) patients in whom RTEs were identified on CT but were not included in the op report.

CONCLUSIONS: Unexpected and potentially perilous PP component locations are common. Pelvic CT prior to secondary PP surgery can help an implanter plan surgical approach, anticipate adjunctive surgical maneuvers (i.e. RTE sling), and definitively determine if RTEs are present. CT can also identify high risk cases in which planned involvement or availability of other specialists may be prudent (e.g. for laparoscopic retrieval of an IP reservoir, see Figure).

Figure: Preoperative CT scan with intraperitoneal penile prosthesis reservoir (arrow) and corresponding laparoscopic finding at time of penile prosthesis revision surgery



Source of Funding: none

PD44-12**20-YEAR FOLLOW-UP AFTER PENILE PROSTHESIS IMPLANTATION – FUNCTIONAL AND QUALITY OF LIFE OUTCOMES**

Francesco Chierigo*, Paolo Capogrosso, Federico Dehò, Eugenio Ventimiglia, Walter Cazzaniga, Luca Boeri, Edoardo Pozzi, Nicolò Schifano, Rani Zuabi, Federico Belladelli, Milan, Italy; Vincenzo Mirone, Naples, Italy; Francesco Montorsi, Andrea Salonia, Milan, Italy

INTRODUCTION AND OBJECTIVES: Hydraulic penile prostheses have shown an overall good mechanical reliability up to 10 years after surgery. However, few data have been published over 10 years. We looked at long-term complications, functional and quality of life (QoL) outcomes following 3-piece inflatable penile prosthesis

implantation (IPP) in patients treated more than 17-years ago at a single center.

METHODS: Baseline, perioperative and follow-up (FU) data of 51 consecutive patients submitted to IPP before 2001 were analyzed. All patients were implanted with AMS (CX/Ultrex plus) 3-piece prostheses. Patients were reassessed to evaluate rate of complications and functional outcomes. The validated questionnaire Quality of Life and Sexuality with Penile Prosthesis (QoLSPP) was used to assess patient's QoL. Kaplan Meier analysis estimated the probability of prosthesis survival (defined as working device/not-explanted). Cox regression analysis assessed predictors of IPP failure.

RESULTS: Median (IQR) FU was 206 months (145, 257). Etiology of erectile dysfunction (ED) was vasculogenic (N=20; 39%), Peyronie disease (N=15; 29%), pelvic surgery (N=4; 7.8%), organic other than vasculogenic (N=3; 5.9%) and others (N=9; 18%). Of 51, 42 (83%) and 9 (17%) patients were implanted with either a penoscrotal or a suprapubic approach, respectively. Throughout the FU, 24 (49%) patients experienced complications [mechanical failure (79%); pain (12%); orgasmic dysfunctions (4.2%); device infection (4.2%)]. The estimated IPP survival was 53% (95%CI: 36-67) at 20-year FU. Baseline characteristics (age; Charlson Comorbidity Index; BMI; ED etiology) were not significant predictors of IPP failure over time at Cox regression analysis. At 20-year FU, 41% (95%CI 19-49) were still using the device. Among them, QoLSPP median (IQR) domain scores were high: functional 22/25 (20, 23), relational 17/20 (15, 18), personal 14/15 (12, 15), and social 14/15 (11, 15).

CONCLUSIONS: Long-term FU data after penile prostheses implantation showed that almost 50% of the devices still properly work after 20 years, with 40% of patients still using the device with high satisfaction and QoL outcomes. Both patients and physicians should be aware of the long life and outcomes of IPP.

Source of Funding: none

Prostate Cancer: Localized: Surgical Therapy II**Podium 45**

Sunday, May 5, 2019

9:30 AM-11:30 AM

PD45-01**ASSOCIATION OF LOCAL ANAESTHETIC WOUNDS INFILTRATION AND ULTRASOUND TRANSVERSUS ABDOMINAL PLANE (US-TAP) BLOCK IN PATIENTS UNDERGOING ROBOT-ASSISTED RADICAL PROSTATECTOMY: A DOUBLE-BLIND RANDOMIZED CONTROLLED TRIAL**

Giovanni E. Cacciamani*, Nicola Menestrina, Marco Pirozzi, Paolo Corsi, Davide De Marchi, Davide Inverardi, Tania Processali, Nicolò Trabacchin, Mario de Michele, Alessandro Tafuri, Marco Sebben, Maria Angela Cerruto, Vincenzo De Marco, Filippo Migliorini, Antonio Benito Porcaro, Walter Artibani, Verona, Italy

INTRODUCTION AND OBJECTIVES: To determinate benefits of the association of local anaesthetic wounds infiltration and US-TAP-block with ropivacaine on postoperative pain, early recovery and hospital stay in patients undergoing robot assisted radical prostatectomy (RARP).

METHODS: The study is double-blinded randomized controlled trial. Our hypothesis was that the association of wound infiltration and US-TAP block with Ropivacaine would decrease immediate postoperative pain and opioids use. Primary outcomes included postoperative pain and opioids demand during the hospital stay. Secondary outcomes were nausea/vomiting rate, stool passing time,

use of pro-kinetics, length of hospital stay and 30-days readmission to the hospital for pain or other US-TAP-block related complications

RESULTS: A total of 100 patients who underwent RARP were eligible for the analysis; 57 received the US-TAP block with 20 ml of 0.35% Ropivacaine (US-TAP-block group) and 43 did not receive US-TAP block (no-US-TAP group). All the patients received the local wound anaesthetic infiltration with 20 ml of 0.35% Ropivacaine. US-TAP block group showed a decreased mean NRS (2.7vs1.8; p=0.04) and reduced use of opioid (8 vs 2; p=0.01) in the first 24 h. Moreover, we found a shorter mean LOS (4.7 vs 4.2; p= 0.04) with a reduced use of pro-kinetics during the hospital stay (31 vs 12; p<0.001). No US-TAP-block related complications to were reported.

CONCLUSIONS: Association of anaesthetic wound infiltration and US-TAP block with Ropivacaine as part of a multimodal analgesic regimen can be safely offered to patients undergoing RARP and ePLND. It improves the immediate post-operative pain control, reducing opioids administration and is associated to a decreased use of pro-kinetics and shorter hospital stay.

	Entire Cohort		US-TAP Block		p-value
			no	yes	
Day of the Surgical Procedure					
First NRS in ward, mean (SD)	2,5 (2,9)	2,7 (3,1)	2,2 (2,6)	0,63	
3 p.m. NRS, mean (SD)	2,8 (2,6)	3,3 (2,5)	2,4 (2,7)	0,1	
11 p.m. NRS, mean (SD)	1,7 (2,1)	1,9 (2,3)	1,5 (2,0)	0,42	
24 hours NRS, mean (SD)	2,2(1,9)	2,7 (2)	1,8 (1,8)	0,04*	
Nausea, n (%)	21 (21)	7 (16,2)	14 (24,5)	0,32	
Vomiting, n (%)	3 (3)	0 (0)	3 (5,3)	0,25	
Stool passing, n (%)	2 (2)	2 (4,6)	0 (0)	0,19	
n. of painkiller dose, mean (SD)	1,4 (0,9)	1,3 (1)	1,5 (0,8)	0,14	
Use of Opioids Rescue Dose, n (%)	10 (10)	8 (18,6)	2 (3,5)	0,01*	
I Post-operative day					
7 a.m NRS, mean (SD)	2,1 (2,4)	2,3 (2,5)	2 (2,4)	0,61	
3 p.m. NRS, mean (SD)	1,45 (1,9)	1,8 (2)	1,1 (1,8)	0,08	
11 p.m. NRS, mean (SD)	1,7 (2,5)	1,6 (2,6)	1,7 (2,4)	0,81	
24 hours NRS, mean (SD)	1,7 (1,6)	1,9 (1,9)	1,6 (1,4)	0,36	
Nausea, n (%)	9 (9)	4 (9,3)	5 (8,8)	1	
Vomiting, n (%)	4 (4)	2 (4,6)	2 (3,5)	1	
Stool passing, n (%)	15 (15)	9 (20,9)	6 (10,5)	0,25	
n. of painkiller dose, mean (SD)	1,3 (1,1)	1,3 (1,1)	1,2 (1,1)	0,88	
Use of Opioids Rescue Dose, n (%)	3 (3)	2 (4,6)	1 (1,7)	0,42	
II Post-operative day					
7 a.m NRS, mean (SD)	1,2 (2,0)	1,6 (2,4)	0,8 (1,5)	0,07	
3 p.m. NRS, mean (SD)	0,9 (1,7)	1,4 (2)	0,6 (1)	0,05	
11 p.m. NRS, mean (SD)	0,7 (1,7)	0,8 (1,9)	0,6 (1,6)	0,56	
24 hours NRS, mean (SD)	0,9 (1,2)	1,3 (1,5)	0,7 (1)	0,06	
Nausea, n (%)	2 (2)	1 (2,3)	1 (1,7)	1	
Vomiting, n (%)	0 (0)	0 (0)	0 (0)	-	
Stool passing, n (%)	49 (49)	19	30	0,41	
n. of painkiller dose, mean (SD)	0,7 (0,9)	0,8 (1)	0,6 (0,8)	0,45	
Use of Opioids Rescue Dose, n (%)	0 (0)	0 (0)	0 (0)	-	
III Post-operative day					
7 a.m NRS, mean (SD)	0,2 (0,6)	0,2 (0,6)	0,2 (0,5)	0,8	
3 p.m. NRS, mean (SD)	0,2 (0,8)	0,2 (0,5)	0,1 (0,7)	0,13	
11 p.m. NRS, mean (SD)	0,2 (0,7)	0,3 (0,8)	0,1 (0,4)	0,34	
24 hours NRS, mean (SD)	0,2 (0,5)	0,1 (0,4)	0,2 (0,5)	0,67	
Nausea, n (%)	2 (0)	1 (2,3)	1 (1,7)	1	
Vomiting, n (%)	1 (1)	1 (2,3)	0 (0)	0,44	
Stool passing, n (%)	83 (83)	36 (83,7)	47 (82,4)	1	
n. of painkiller dose, mean (SD)	0,3 (0,6)	0,4 (0,7)	0,2 (0,5)	0,22	
Use of Opioids Rescue Dose, n (%)	0 (0)	0	0	-	

Source of Funding: none

**PD45-02
OPIOID USE BEFORE AND AFTER RADICAL PROSTATECTOMY:
NATIONWIDE POPULATION-BASED STUDY**

Walter Cazzaniga*, Milano, Italy; Stacy Loeb, New York, NY; Hans Garmo, Uppsala, Sweden; David Robinson, Jonköping, Sweden; Pär Stattin, Uppsala, Sweden

INTRODUCTION AND OBJECTIVES: In the United States, there are more than 115 deaths per day from an overdose of opioids. Previous studies from the US have reported that approximately 5% of opioid-ive surgical patients become chronic opioid users after a single prescription postoperatively. The aim of our study was to examine the risk of chronic opioid use following radical prostatectomy (RP) in a different health care system.

METHODS: We assessed filled prescriptions for opioids in 25,703 men in Prostate Cancer data Base Sweden (PCBaSe)[1] who

had undergone retropubic or robot-assisted RP in 2007-2018. Opioid use was examined in three time periods: preoperative (13 months to 1 month before RP), perioperative (1 month before and 1 month after RP), and postoperative (1 to 12 months after RP). Multivariable logistic regression was used to assess the risk of transition to chronic opioid use, defined as one or more opioid prescription(s) in three consecutive months more than two months after surgery.

RESULTS: The median age at RP was 64 years and 86% of men had a Charlson comorbidity index of 0. A total of 1.9% of men had filled an opioid prescription in the preoperative period, followed by a spike in the perioperative period (59%), which sharply decreased in the second month. In the postoperative period, the percentage of men who had filled an opioid prescription was 2.3% (i.e 0.4% higher than in the preoperative period). Among chronic late users, 43% were new users. Unmarried status, low educational level, retropubic RP, high comorbidity, and more advanced risk category were predictors of transition to chronic use of opioids.

CONCLUSIONS: Slightly more than half of Swedish men received opioid prescriptions surrounding radical prostatectomy. The absolute number of patients who became chronic opioid users after surgery was low. Socioeconomic status, comorbidity, cancer characteristics, and surgical approach were all associated with risk of becoming a new chronic user after radical prostatectomy.

Source of Funding: none

**PD45-03
SUPERIOR SHORT- AND LONG-TERM CONTINENCE AFTER
EARLY MICTURITION ON DAY TWO AFTER ROBOT-ASSISTED
RADICAL PROSTATECTOMY WITH SUPRAPUBIC TUBE
PLACEMENT – A RANDOMIZED PROSPECTIVE TRIAL**

Nina Harke*, Essen, Germany; Christian Wagner, Katarina Urbanova, Mustapha Addali, Jorn H. Witt, Gronau, Germany

INTRODUCTION AND OBJECTIVES: In former studies, suprapubic tube placement after radical prostatectomy has been shown to be equivalent to a transurethral catheterization concerning complication rates and stricture rates with potential benefits regarding patients' comfort. This prospective randomized trial elucidates the perioperative and long-term functional outcomes depending on type and duration of catheterization after robot-assisted radical prostatectomy.

METHODS: 198 patients were randomized prospectively (May 2016-June 2017): a transurethral catheter was placed in the control group with micturition on postoperative day (POD) 5 (A), while a suprapubic tube (SPT) was used in group B and C. In B, micturition was allowed on POD 5, in C on POD 2. To investigate patient comfort, numeric rating scale for movement and rest was used and usage of pain medication. Functional outcomes were evaluated with a 12- hour Pad test, residual volume analysis on POD 5 (A, B) and POD 2 (C), usage of pads after 4 weeks and up to 12 months and IPSS.

RESULTS: After drop-out of 11 patients, no statistically significant differences could be found in patients' characteristics, perioperative or tumor-related data. Median overall bother was comparable for periods of movement (NRS for A: 2.4; B: 2.1; C: 2.2; p=0.39) and for rest (NRS for A: 1.4; B: 1.4; C: 1.2; p=0.80) with similar intake of pain medication, p=0.07. No differences could be observed in catheter related complications (p=0.86) and prolonged catheterization time occurred in six patients (A: 3; B: 1; C: 2; p=0.61). Median residual urine volume after removal of the catheter was 17 ml for A, 7 ml for B and 11 ml for C (p=0.07). A significantly better continence was observed for group C with 14 ml vs. 30 ml (A) and 24 ml (B) in the 12-hour PAD test on the day of catheter removal, p=0.007. After four weeks, 63% of the patients in C were continent (defined as use of no pad/day) compared to 33% in A and 41% in B, p=0.004. After 12 months, 76% patients were continent in A, 87% in B and 94% in C, p=0.023.

CONCLUSIONS: Suprapubic tube placement instead of transurethral catheterization in robot-assisted radical prostatectomy can be performed safely without an increased risk of perioperative