was compared with the non-endometriosis cohort among the two subgroups by Cox regression after adjusting for confounding factors.

**Results:** In addition to the representative average age, subgroup 2 had similar rates of comorbidities as the general population. The study was both externally and internally valid. The risk of IC/BPS in the endometriosis cohort (n = 18006) was significantly higher than in the non-IC/BPS cohort (n = 389099) in subgroup 2 (HR = 2.091, 95% CI 1.641–2.663). The mean time to IC/BPS after diagnosis of endometriosis was 3.76 years.

**Conclusion:** Endometriosis has association with IC/BPS in our database. Caregivers should cautiously evaluate the possibility of IC/BPS in women with diagnosis of endometriosis.

**MP3-3. DYSpareunIA RADIATED TO THE BLADDER MAY BE A POTENTIAL PROGRESSIVE PHENOTYPE OF THESE PATIENTS WITH INTERSTITIAL CYSTITIS/BLADDER PAIN SYNDROME (IC/BPS)**

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**Purpose:** Intestinal cystitis/bladder pain syndrome (IC/BPS) is a chronic disease characterized by a constellation of symptoms, including pelvic pain, pressure, and discomfort perceived to be related to the bladder with frequency, persistent urge, or nocturia in the absence of bacterial infection or other identified pathologic disease. A previous study established that interstitial cystitis/bladder pain syndrome (IC/BPS) patients had significantly more dyspareunia and fear of pain than healthy controls. Moreover, recent studies revealed sexual pain may be the one of "UPOIN" phenotypes (Urinary, psychosocial, organ specific, infection, neurogenic, tenderness) in IC/BPS patients. We proposed that patients diagnosed of IC/BPS with the presence of dyspareunia could be a specific phenotype and compared as a separate group with a pure IC/BPS without presence of dyspareunia. The purpose of this study is to examine the relationships between lower urinary tract symptoms including the symptom profile, using validated questionnaires, duration of symptoms, anesthetic maximal bladder capacity (MBC), severity of glomerulation, and dyspareunia in IC/BPS patients.

**Materials and Methods:** A total of 156 IC/BPS female patients were included in this study. The diagnosis was made on the basis of chronic (>6 weeks) pelvic pain, pressure, or discomfort perceived to be related to the bladder and frequency, persistent urge, or nocturia in the absence of infection or other identifiable causes. There were two questions for dyspareunia history: (1) "Do you feel pain during or after sexual intercourse" and (2) "At which site was the pain located (bladder, vagina, or both)". Urogenital prolapse, vaginal candidiasis, and cervical, uterine, and ovarian cancers were excluded. All women completed measures of pain severity (visual analog scale) and bladder symptom severity [IC Symptom Index, IC Problem Index, and the Pelvic Pain and Urinary/Frequency (PUF) scale]. Respondents were asked to recall if they experienced any sexual pain during or after sexual intercourse in the past 1 year. Cystoscopic hydrodistension during general anesthesia was performed for 5 minutes and maximal bladder capacity was also measured. In our opinions, the conservative treatment for chylous ascites after urological surgery was feasible.

**Results:** Of the women with a current sexual partner, 61% (96/156) reported dyspareunia during or after sexual intercourse. Of the 96 dyspareunia respondents, 46% (44/96) reported pain in the bladder only, 43% (41/96) in the vagina only, and 11% (11/96) in both the bladder and the vagina. Patients with dyspareunia complained of more severe urological pain (p = 0.02), a higher PUF scale score (p < 0.01), and larger anesthetic maximal bladder capacity (p = 0.04) than patients without dyspareunia. However, patients with dyspareunia at the bladder only more severe urgency (p = 0.03) and larger MBC (p = 0.04) compared to those without dyspareunia. When examining patients with dyspareunia at the vagina only versus those without dyspareunia, no difference was found in bladder symptom and MBC. There were no differences in symptomatic severity and MBC between patients with dyspareunia at the bladder and those at the vagina. There were no differences in the severity of glomerulation between patients positive and negative for dyspareunia (p = 0.18). Moreover, dyspareunia at the vagina only and that at the bladder only showed no differences in severity of glomerulation (p = 0.23, vagina only; p = 0.24, bladder only).

**Conclusion:** IC/BPS women with dyspareunia have significantly more severe urological pain and a higher PUF scale score than women without dyspareunia. Patients with dyspareunia radiated to the urinary system (bladder) show more severe lower urinary tract symptoms (urgency) and larger anesthetic MBC. Physicians should consider sexual pain disorder in the management of patients with IC/BPS and use the PUF scale to evaluate not only IC-specific lower urinary tract symptoms but also sexual pain disorder.

**Other**

**MP3-4. POSTOPERATIVE CHYLOUS ASCITES AFTER UROLOGICAL SURGERY: A 10-YEAR REVIEW AT CHUNG-SHAN MEDICAL UNIVERSITY HOSPITAL**

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Postoperative chylous ascites is a rare complication of urological surgery. We reviewed the chart of urological operation in the past 10 years in Chung Shan Medical University Hospital, and we are going to report and discuss four cases of postoperative chylous ascites in the article. The first two cases were patients underwent nephrectomy with bladder cuff excision for ureteral carcinoma, the third case was the one underwent radical nephrectomy with lymph node dissection, and the last case was a patient had renal transplantation. Adequate survey and immediately diagnosis were important since milky-white fluid was found in the drain bag. We checked the triglycerides level of the drainage. Then, we did conservative treatment for the postoperative chylous ascites patient with nothing per os (NPO) and total parenteral nutrition (TPN) given via central line for at least seven days. Since the daily drain amount decreased and became steady, the color of drainage turned from milky-white to light yellow or serosanguinous, a diet containing low fat and/or medium chain triglycerides was asked to follow, and last for weeks. Elongating the time of drain placement was suggested, and even more let the patient discharged home with the drain. The outcome of all four patients were good, there is no more uncomfortable abdominal symptoms or milky-white fluid accumulated. In our opinions, the conservative treatment for chylous ascites after urological surgery was feasible.

**MP3-5. DUPLEX COLLECTING SYSTEMS: PRESENTATION, MORBITDITY, AND TREATMENT**

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**Purpose:** Duplex collecting systems is the most common congenital anomaly, with an incidence of 0.8–1% during urinary tract development. They are usually asymptomatic and diagnosed incidentally by radiological survey for other reasons. Duplex collecting systems can be divided into complete and incomplete type and may associate with other anomalies. However, there is minimal literature on the review of this entity, its associated anomalies and complications. The purpose of this study is to review the presentations, characteristics, morbidities and treatment modalities in patients with duplex collecting system.

**Materials and Methods:** We retrospectively evaluate the database of patients with duplex collecting systems both from chart records and radiological image studies with the term “duplication” or “duplex” between January, 2010 and September, 2015.