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 Intersitial Cystitis/Bladder Pain Syndrome (IC/BPS)**

Wei-Chih Chen¹, Ming-Huei Lee¹,², Huei-Ching Wu¹,². ¹Department of Urology, Feng Yuan Hospital, Ministry of Health, and Welfare, Taichung, Taiwan; ²Central Taiwan University of Science and Technology, Taichung, Taiwan

**Purpose:** Intersitial cystitis/bladder pain syndrome (IC/BPS) is a chronic disease characterized by a constellation of symptoms, including pelvic pain, pressure, or 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 "UPOINT" 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 consensus of IC/PBS proposed by the Society for Urodynamics and Female Urology criteria in 2008. All patients were diagnosed on the basis of chronic (>6 weeks) pelvic pain, pressure, or discomfort perceived to be related to the urinary bladder accompanied by at least one other urinary symptom, such as 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. We used Chi-square tests to evaluate the associations between dyspareunia condition (presence or absence) and severity of glomerulation. Significance was set at p < 0.05.

**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 urolgical 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 urolgical 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**

Chi-Hang Hsiao¹, Sung-Lang Chen¹,², Yu-Lin Kao¹,², Shao-Chuan Wang¹, Wen-Jung Chen¹, Tzu-Yi Hsieh¹. ¹Department of Urology, Chung Shan Medical University Hospital, Taichung, Taiwan; ²School of Medicine, Chung Shan Medical University, Taichung, Taiwan, ROC.

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 cuf excision for uterohelial 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.
Results: Two hundred and three patients were identified with age range from 1 month to 90 years (median: 53 years). Female accounted for 54.6% and 45.4% were male. More than half were incidental finding (55.6%) with the most common investigational tool as abdominal/pelvic computed to-mography (CT: 43.4%, intravenous pyelogram: 36.5%, sono: 10.8%, mag-netic resonance: 7.9%, retrograde pyelogram: 0.5%, cystoscopy: 0.5%, ureteroscopy: 0.4%). Patients with clinical manifestations included urinary tract infection, hematuria, flank pain, and incontinence. Most duplex ureters were incomplete (73.8%) and the conjoined level were left upper third: 45.4%; right upper third: 26.7%; left middle third: 12%; right middle third: 8.7%; left lower third: 4.6%; right lower third: 2.6% in orders. The most common morbidity was urolithiasis (29.6%) and ureterorensic lithotripsy was applied for most of the cases. Eight of 24 patients with complete duplication had associated anomalies (ectopic ureteral orifice, ureterocele, hydronephrosis, UPJO).

Conclusion: Duplex collecting systems are common but clinically insignifi-cant. In this study, complete duplication showed higher incidence of ectopic ureter and surgical intervention was needed. Physicians should keep such developmental abnormalities in mind and proceed to prompt investigation and management.

MP3-6.
THE EXPERIENCE OF TREATMENT OF TESTICULAR TORSION IN A SINGLE ACADEMIC CENTER

Tzu-Hsiang Hsu, Eric Yi-Hsui Huang, Yen-Hwa Chang, William J.S. Huang, Hsiao-Jen Chung, Howard H.H. Wu, Tzu-Ping Lin, Chi-Cheh Lin, Y.H. Fan, Zi-jun Wei, Alex T.L. Lin, Kuang-Kuo Chen, Department of Urology, Taipei Veterans General Hospital, Taipei, Taiwan; 2 Department of Urology, School of Medicine, Taiwan; 3 Shu-Tien Urological Science Research Center, National Yang-Ming University, Taiwan.

Purpose: Testicular torsion is a urologic emergency and delayed diagnosis and management could result in testicular death. This study aimed to keep such developmental abnormalities in mind and proceed to prompt investigation and management.

Materials and Methods: From January, 2000 to February, 2016, patients diagnosed as testicular torsion in our institute were enrolled. The demo-graphic data, clinical presentation, pre-operative diagnosis e.g. scrotal ultrasound finding and surgical findings were investigated.

Results: Fifty-one patients were identified, mean age was 20.8 ± 16.1 years (range 0–86 years). The distribution of testicular torsion in each season were 15.6% (spring), 15.6% (summer), 17.6% (autumn) and 51% (winter). Forty seven patients (92.2%) presented to hospital with symptom of scrotal pain. The laterality was 30 (58.8%) in left, 17 (33.3%) in right, and 3 (5.9%) in bilateral testicles. Thirty-nine cases received color Doppler scrotal ultrasound for diagnosis, demonstrated decreased testicular blood flow in 11 cases and no testicular blood flow in 13 cases. Among 51 patients, 14 cases received orchietomy, 1 received partial orchietomy, 27 cases received orchiopexy and 4 patients did not undergo surgery. The salvage rate of testis in patients with testicular torsion was 72.5% and contralateral orchiopexy was performed in 33 cases (70%).

Conclusion: In our experience, almost half of the cases occurred in winter. Doppler ultrasound was critical in the diagnosis of testicular torsion. The salvage rate was high if immediate surgery offered.

MP3-7.
IATROGENIC TRAUMA OF URETER AND U-BLADDER DURING GYN AND CRS OPERATION

Lung-Feng Cheng, Lun-Hsiang Yuan, Chia-Cheng Yu, Division of Urology, Department of Surgery, Kaohsiung Veterans General Hospital, Taiwan; 2 Division of Urology, Department of Surgery, Tri-Service General Hospital, National Defense Medical Center, Taiwan; 3 Department of Pharmacy, Tajen University, Taiwan.

Purpose: According to EAU Guidelines on iatrogenic Trauma, ureter and u-bladder were thought most injured by medical procedures. Organs near ureter and u-bladder: colon, female genital organ. We want to evaluate non-urologic (CRS/GYN) ureter & bladder injury incidence and stratify risk groups and evaluate prognosis.

Materials and Methods: We collect the patients who suffered from iatrogenic trauma of urinary tract in VGHKS (Kaohsiung Veterans General Hospital) from 2005 to 2015 via medical chart. We retrospectively reviewed chart about CRS, GYN, ureter injury and bladder injury. Outcome was defined urinary condition post-operation one year.

Results: Total 70 patients were noted, respectively 20 ureteral injury and 50 bladder injury. During ureteral injury, 8 in GYN, 12 in CRS surgery, 3 CRS and 1 GYN patients were delayed diagnosed. Poor outcome: One CRS pa-tient needed permanent PCN and one GYN patient was expired. During bladder injury, 40 in GYN, 10 in CRS surgery, all diagnosed intra-operation. Poor Outcome: 1 iatral conduit for persisted urine leakage.

Conclusion: Bladder injury occurred very frequently as opposed to ure-teral injury. The variety of injured states, difficulty of diagnosis, and time to complete cure were much greater among patients with ureteral injury. Early diagnosis and early urologic intervention are necessary to prevent the occurrence of delayed urological complications.

MP3-8.
URETEROSCOPE-AID REINSERTION OF DISLODGED PIGTAIL Nephrostomy TUBE CANNOT BE INSERTED MANUALLY

Shun-Kai Chang, Yeong-Chin Jou. Department of Urology, Ditmanson Medical Foundation Chia-Yi Christian Hospital, Chia-yi, Taiwan, ROC.

Purpose: Percutaneous nephrostomy (PCN) is widely used in hydro-nephrosis by ureteral obstruction caused with variety clinical situation. If the tube becomes dislodged, tube exchange becomes more difficult or impossi ble sometimes. Neither nephrostomy tractogram by radiologist to pass over guidewire or renal puncture for new PCN creation is subse-quentely needed. We present several cases with ureteroscope aid that is useful in replacing dislodged nephrostomy tubes.

Materials and Methods: A total of 9 dislodged pigtail nephrostomy tube cases received ureteroscope-aid reinsertion between 2013 and 2016. Manual reinsertion of guidewire and pigtail have been tried before ure-teroscopy-aid procedure in all of the 9 patients but failed. Ureteroscope was inserted through the old PCN opening and the missed access nephrostomy tract was re-identified under the inspection of ureteroscope. All procedures were under local anesthesia. The clinical features of these 9 patients were evaluated by retrospective chart review.

Results: Seven cases received the procedure within 24 hours after pigtail nephrostomy tube dislodged. The others are 2 days and 8 days, respec-tively. The interval after PCN creation is from 2 weeks to 10 months. Eight cases were successfully reinserted pigtail nephrostomy tube by ureteroscopy aid. The operation time is from 15 minutes to 30 minutes. Only one case failed and received renal puncture for new PCN creation. There were no severe related complications except for one case with post-operative fever 1 day after procedure and was admitted for antibiotic treatment without any sequel.

Conclusion: Reinsertion of dislodged pigtail nephrostomy tube by the aid of ureteroscope is a relatively simple, safe and effective procedure which can be performed under local anesthesia. It may decrease the necessity of new PCN tract creation and reduce the related complications.

MP3-9.
LOCALIZED AMYLOIDOSIS OF THE URINARY TRACT – EXPERIENCE OF VGHTC

Po-Chi Liao, Hao-Chung Ho, Kun-Yuan Chiu, Chuan-Shu Chen, Chi-Feng Hung, Chen-Li Cheng, Jian-Ri Li, Shian-Shiang Wang, Cheng-Kuang Yang, Cheng-Chen Chen, Yen-Chuan Ou. Division of Urology, Department of Surgery, Taichung Veterans General Hospital, Taiwan.

Purpose: Localized amyloidosis of the urinary tract is a rare condition. Due to its similar clinical presentation with malignancy of urinary tract, it is important for clinicians to recognize this condition.

Materials and Methods: We collect patients diagnosed as localized amyloidosis of the renal pelvis, ureters, urinary bladder, or urethra from 2000 to 2015. Patients with systemic amyloidosis were excluded and all