urinary symptoms such as frequency, urgency, and nocturia. Previous study reported that patients with IC/BPS during the 3-year follow-up period showed increased risk of bladder cancer than healthy controls. However, a potential detection bias may exist when elevated risk for bladder cancer within three years immediately following an IC/BPS diagnosis. There should be noted that it is also common for IC/BPS to coexist with either unexplained medical conditions, such as fibromyalgia, irritable bowel syndrome, and chronic fatigue syndrome or confusible diseases during diagnosis of IC/BPS, such as urolithiasis and urinary tract infection. Therefore, we re-examined the risk of bladder cancer in a large population based cohort of individuals with a new diagnosis of IC/BPS to assess a potential detection bias.

Materials and methods: We performed a retrospective cohort study of Longitudinal Health Insurance Database 2000 with newly diagnosis of IC/BPS from 2002 through 2010. After limiting our sample to patients with IC/BPS diagnosis (ICD-9 code 595.1 at least once during the study period), we identified an IC/BPS cohort. We then excluded patients with diagnosis of bladder cancer (ICD-9 codes, 180-189) before IC/BPS diagnosis. The primary outcome was the event of bladder cancer, determined by the record with ICD-9 codes, 180-189 after the entry date. We defined the logit of predicted probability of bladder cancer as a propensity score using the following baseline characteristics: sex, age, date of diagnosis, comorbidity, and smoking status. Subjects with IC/BPS were matched on a one-to-one basis with subjects with non-IC/BPS. We used chi-square tests to evaluate associations between events of bladder cancer and patient-level covariates (age, sex, comorbidity, smoking status). Next, we compared primary outcome (events of bladder cancer) between IC/BPS and non-IC/BPS cohort using multiple logistic regression. Analyses were performed using SPSS version 22.

Results: After adjusted with propensity score-matching, we identified 1642 patients with diagnosis of IC/BPS and 1642 patients with non-IC/BPS cohort. There is no statistically significant association between comorbidity and bladder cancer except urolithiasis (P < 0.001) and urinary tract infection (P = 0.03). During the study period, 20 (1.2%) IC/BPS patients and 30 (1.8%) non-IC/BPS patients were diagnosed as having bladder cancer. Chi-square test showed no difference of bladder cancer incidence between IC/BPS and non-IC/BPS cohort (p = 0.2). Moreover, the multiple logistic regressions estimating the risk of bladder cancer showed no significant association among IC/BPS, sex, urolithiasis, and urinary tract infection except age (B = 0.02, p = 0.005).

Conclusions: Our results imply us that IC/BPS is not related to bladder cancer. The detection bias from previous study may be the results of either an inadequate matching non-IC/BPS cohort or poor controlled confounding factor.

Urolithiasis

MP3-1.
COMPARISON OF EFFICACY OF URETEROSCOPIC LITHOTRIPSY BETWEEN PNEUMATIC LITHOCLAST AND HOLMIUM LASER IN MANAGEMENT OF UPPER URETERAL STONE

Li-Chen Chen, Marcelo Chen, Wun-Rong Lin, Wen-Chou Lin, Huang-Kuang Chang, Stone Yang, Jong-Ming Hsu, Wei-Kung Tsai, Pai-Kai Chiang, Yung-Chiong Chow. Department of Urology, Mackay Memorial Hospital, Taipei, Taiwan

Purpose: To evaluate the efficacy of ureteroscopic lithotripsy with pneumatic lithoclast and laser in management of upper ureteral stone.

Materials and methods: We retrospectively review the medical record. Patients who underwent ureteroscopic lithotripsy by pneumatic lithoclast and laser between January 2012 to January 2013 for upper ureteral stone in Mackay Memorial Hospital were included. Cases with concurrent UTI and acute renal failure were excluded. Invisible stones, loss follow-up or concurrent middle or lower ureteral stones were also excluded. Patient age, method of lithotripsy, stone size and burden (based on KUB or CT), ureteral catheter insertion and further ESWL or URSL for residual stone were recorded.

Results: There were 216 patients identified. A total of 158 patients met criteria (118 patients in pneumatic lithoclast group and 40 patients in laser group). One hundred and seventy-eight ureteral stones (135 in pneumatic lithoclast group and 43 in laser group respectively) were treated. The mean age of pneumatic lithoclast and laser group was 53.5 years (22-92 years) and 52.9 years (21-69 years) respectively. The stone size and burden in both groups were similar (p = 0.44 and 0.45 respectively). There was a mild trend of better stone free rate and lower secondary intervention rate in laser group (p = 0.07 and p = 0.09 respectively). No severe complication (>Grade III Clavien classification) were observed.

Conclusions: Use of laser lithotripsy in management of upper ureteral stone was associated with lower rate of ureteral catheter insertion. We also observed a weak association of better stone free rate and lower secondary intervention rate in laser lithotripsy group. They were both safe procedures without major complications.

MP3-2.
DO WE NEED PROPHYLACTIC ANTIBIOTICS PRIOR TO EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY? A RANDOMIZED CONTROL TRIAL WITH PROSPECTIVE FOLLOW-UP OF ASSOCIATED COMPLICATIONS

Yin-Buh Liu, Cheng-Hsing Hsieh, Shang-Jen Chang, Chia-Da Lin, Stephan Yang. Division of Urology, Taipei Tzu Chi Hospital, The Buddhist Tzu Chi Medical Foundation, School of Medicine, Buddhist Tzu-Chi University, Hualien, Taiwan

Purpose: To compare the efficacy of prophylactic antibiotics in reduction of post-surgical infections in patients undergoing extracorporeal shock wave lithotripsy (ESWL).

Materials and methods: The study is a double-blind, prospective, randomized placebo control trial. Between 2012 and 2014, patients with preoperative sterile urine undergoing ESWL were randomly allocated by the randomization ratio of 1:1 to receive prophylactic antibiotics with single-dose oral levofloxacin (500mg) or no treatment (control group), respectively. Urine analysis and urine cultures were obtained between postoperative day 5 and 7. Pyuria was defined as ≥10 WBC/hpf. Significant bacteriuria was defined as ≥10^5 cfu uropathogens/ml. Febrile urinary tract infection (UTI) was defined as body temperature of 38.0 Celsius degree with pyuria or significant bacteriuria within 7 days postoperatively.

Results: Initially, 274 patients underwent randomization with 139 and 135 patients in the control and levofloxacin group, respectively. Finally, 206 patients (106 with placebo and 100 with levofloxacin) with complete followup of urine analysis were eligible for analysis. The rates of postoperative pyuria were not significantly different in patients with and without prophylaxis (8% vs. 4.7% p = 0.33). There was also no significant difference in rates of bacteriuria in patients with and without prophylaxis (0% vs. 1%, p = 0.49). Patients without followup of urine analysis and urine culture were contacted by telephone and there was only patients with post-operative fever in the levofloxacin group (0% vs. 0.7%, p = 0.49). As preliminary results of the interim analysis revealed no benefit of levofloxacin in preventing post-ESWL pyuria, bacteriuria and febrile urinary tract infection, we terminated the study early before pre-planned sample size is achieved.

Conclusion: The incidence of asymptomatic and febrile urinary tract infection is low in patient underwent ESWL with pre-operative sterile urine. Therefore, prophylactic antibiotics in these patients may be unnecessary.

MP3-3.
EXPERIENCE OF TUBELESS PERCUTANEOUS NEPHROLITHOTOMY WITH HEMOSTATIC SEALANT USE

Chi-Chih Lien, Yin-Ting Liu, Chi-Yun Lan, Kai-Yi Tzou, Su-Wei Hsu, Wei-Tang Kao, Kuan-Chou Chen 1,2. 1Department of Urology, Taipei Medical University-Shuang Ho Hospital, Taipei, Taiwan; 2Department of Urology, School of Medicine, College of Medicine, Taipei Medical University, Taiwan

Purpose: To evaluate the experience of tubeless percutaneous nephrolithotomy with hemostatic sealant use.