

2. Did your child improve after surgery in his/her enuretic episodes? If yes was this:
- 2.1. A complete stop?
 - 2.2. A partial stop?

We categorized the patients postoperatively into 3 groups:

1. Patients with complete resolution of nocturnal enuresis.
2. Patients with partial improvement.
3. Patients with no change in their complaints.

Partial improvement was defined as a minimum of 50% decrease in the frequency of bedwetting recorded preoperatively. All data were collected between November 2008 and May 2009. The chi-squared test was used to compare the prevalence of NE before and after surgery.

Results: Of the 398 patients 98 were excluded from the study because of incomplete records. The incidence of NE in the entire study group (n=300) before adenotonsillectomy was 30.7% (92 patients). Among the 92 patients, 64 (69.6%) were male, and 28 (30.4%) were female (p=0.001). In 46 patients who agreed to participate in the study 26 (56.5%) had complete resolution, 8 (17.4%) had a partial improvement and 12 (26.1%) had no change in NE following adenotonsillectomy. We observed a partial improvement or complete resolution of NE in 73.9%. To define whether the results related to enuresis were statistically significant, a chi-square test for equal proportions was performed. The chi-square value was found to be 13.131 resulting in p<0.0001. Resolution of OSA symptoms was observed in 100% of these patients postoperatively.

Conclusions: Children with OSA symptoms have a high rate of NE. We have demonstrated that relief of OSA symptoms will also result in complete resolution or partial improvement of NE in more than two-thirds of patients. In the differential diagnosis of a child presenting with NE, OSAS should be kept in mind and the presence of NE should be investigated in a child presenting with OSA symptoms.

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Treatment of the stress incontinence using different types of Trans Obturator Tape (TOT) in women – analysis of failures after surgery

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Introduction and Objectives: The estimation of the efficacy of different types of trans obturator tape in the treatment of the stress urinary incontinence in women and the analysis of the causes of failure after surgery.

Material and Methods: Between October 2003 and June 2008, 160 TOT (outside – inside) procedures were performed. The following tape types were used: Obtape (Porges-Mentor) 70, Aris (Coloplast) 84, Monarc (AMS) 5 and Pelvicol 1. Average age of the patients was 56 years (40–77 years). Max flow rate (Q max) was on average 29.4 ml/sec before the procedure. The follow-up was 6–62 months, 27 on average. In case of a failure after the procedure, gynecological examination, cystoscopy and again a urodynamical examination was performed.

Results: 139 (86.9%) of the patients were cured completely – continence was defined as a lack of any involuntary leakage of urine and ceasing of sanitary pads use. In 14 (8.75%) patients, the recurrence of stress incontinence (SUI), in 2 patients a mixed urinary incontinence and in 5 (3.12%), symptoms of overactive bladder with urge incontinence was found. Among the patients with recurring SUI and mixed urinary incontinence, four (25%) had in the past one or more surgeries of the pelvis floor, one patient one year after procedure was pregnant with a Caesarean section birth, one had a small gynecological procedure (vagina pilipus removing) in the third year since the tape implantation

and this worsened continence. Average age of the patients with the recurrence of the incontinence was 59 years. Tape extrusion into vagina happened in 4 (2.5%) patients. In two cases this was the Obtape (on 70 procedures) (2.8%) and in two Aris (on 84 procedures) (2.4%). All extrusions were on antero-lateral vagina wall. In two patients, the first symptom of the tape extrusion was urinary incontinence recurrence, and two had no symptoms at all. In 7 (4.4%) patients, a postvoiding residual urine with urethra obstruction (Qmax <15 ml/s) was found. Three (1.9%) complete urinary retention happened, one in a patient with neurogenic bladder. one in patient with hypofunction of the detrusor – the tape was removed 5 months after the primary procedure, without incontinence recurrence. One patient, 3 months after CIC voids normally.

Conclusions: 1. TOT is effective method of treatment of SUI in a medium time follow-up – above 85% patients are completely cured. 2. The type of the used tape does not impact the percentage of the patients that are fully cured of SUI and does not impact the risk of the vagina tape extrusion. 3. The recurrence of the urinary incontinence could be the first symptom of the tape extrusion. 4. Having surgeries of the pelvis floor in the past and second gynecological procedures after the tape implantation are a potential cause of recurrence of SUI.

Poster Session 5: Renal disease

Friday, 11 September 2009, 14:50–17:00

Poster room 2

N62

Laparoscopic living donor nephrectomy – first Polish cases experience

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Introduction and Objectives: Despite observed huge progress in understanding the immunological basis of transplantation and the development of new immunosuppressive agents that have significantly improved both the patient and graft survival, still the kidney donation from live volunteers remains the most consistent factor which affects the long-term survival. The first living-related donor nephrectomy was performed in 1953. Since then open surgery has become the standard for many years and thereby, due to the morbidity associated with this technique of organ retrieval, many possible kidney donors were reluctant to donate. The laparoscopic live-donor nephrectomy is the alternative for open approach. We present the first Polish experience of two living-donor laparoscopic nephrectomies performed in our center.

Material and Methods: In 2008 we have performed two living donor nephrectomies using this technique. In both cases left kidney was removed. The first donor was 56 year-old woman, a mother of chronically sick daughter, the second women, 42 year-old, gave her kidney to her husband. The donors were evaluated preoperatively in the nephrology department. The evaluation included medical, surgical and psychosocial suitability for live donation. In both cases we applied the retroperitoneal access which has been routinely used in our center. The kidneys were dissected between the perirenal fatty tissue and the fibrous capsule. The renal artery was identified from its posterior aspect and freed from the surrounding fatty and lymphatic tissue. The renal vein was dissected in order to gain the full, proper length

at the level of transection. Before final retrieving the organ 6 cm muscle-splitting incision was made in left inguinal area.

Results: Warm ischemia time in both cases did not exceed over 2 minutes. Operation time was 210 and 190 minutes and the blood loss was 250 and 100 ml, respectively. The condition of ureters and the vessels in both retrieved kidneys were excellent and it allowed for easy and safe anastomosis with internal iliac vessels and bladder. The postoperative courses were uncomplicated, slightly elevated creatinine level was only observed up to 1.17 and 1.37 ng/ml. The kidneys were implanted in transplantological departments and their immediate function was noted. Currently both donors and recipients are well.

Conclusions: Living donor nephrectomy is a challenging and difficult procedure which should be performed only in centers with experience in laparoscopy of upper urinary tract. Despite efforts of many organizations the situation in Poland concerning organ donation is not satisfactory. One of the reason may be the fear of surgical trauma caused by open nephrectomy and the lack of knowledge about health condition after kidney donating. Applying the laparoscopic approach for living donor nephrectomy can have a positive effect on rate of kidney donation in Poland.

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Natural history of renal tumors in von Hippel-Lindau syndrome

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Introduction and Objectives: The von Hippel-Lindau (VHL) disease is a hereditary cancer predisposition syndrome with autosomal dominant pattern of inheritance, with high penetrance but variable expression, dependent mostly on age. Its prevalence is 1:39 000–1:53 000. The VHL gene, localized to chromosome 3p25–26 belongs to suppressor genes and was identified in 1993. Affected individuals have a risk of cancer and tumor-like lesions, including retinal angiomas, hemangioblastomas of the central nervous system, renal cysts, renal cell carcinomas (RCC), pheochromocytoma, epididymal cysts and cystadenomas, liver and pancreatic cysts. Morphologically renal lesions vary from simple cysts, through hyperplastic cysts with multiple cell layers and cysts containing clear cell carcinoma, to solid renal lesions. Cysts are usually multiple, bilateral in 30%, mostly asymptomatic. They precede solid lesions about 3–7 years. Solid lesions are always RCC. In 10% RCC is a first diagnosed lesion of VHL. Cumulated risk of RCC in 6th decade is ~70%. RCC is a leading cause of death in VHL patients [1–3]. Clinical features of RCC in VHL syndrome comprise multifocality, bilateral lesions, usually with dense fibrotic capsule, rare metastases especially if primary tumor smaller than 3–7 cm, lower grading, and longer 10 years survival comparing with sporadic RCC. It occurs about 20 years earlier than sporadic RCC. Mean rate of growth for solid renal lesions according to a few papers oscillates from 0.26 cm/year (range 0–1.2) [1], through 0.54 (0.26–0.9) [3] to 1.6 (0.2–2.2) [2].

Material and Methods: Retrospective analysis of radiological documentation of the biggest solid lesions of 5 patients with VHL was done. Mean value of the rate of tumor growth for individual patient and mean value for all the group were counted.

Results: The rate of tumor growth for individual patient shows table 1.

Table 1: The rate of tumor growth for individual patient

Patient	1	2	3	4	5
Rate of growth (cm/year)	0.93	1.7	0.71	0.18	0.8

Mean value for all the group is 0.86 cm/year.

Conclusions: All observed renal solid lesions increased with time. The rate of tumor growth in our study is similar to results from the literature. Big differences of studied value necessitate individualized therapeutic approach to each patient.

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The results of multidisciplinary treatment of metastatic renal cell carcinoma

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Introduction and Objectives: Metastatic renal cell carcinoma (mrcc) is characterised by the highest percentage of deaths of all urological tumours. 5-year disease specific survivals after nephrectomy in this group do not cross 10%.

Material and Methods: Group of 138 patients with MRCC: 99 men and 39 women treated in years 1999–2007 is presented (age 30 to 85 years, 59 mean). Organ metastases in 124 patients were diagnosed, in 98 to local lymph nodes (in 14 patients solely), in 84 patients both lymph nodes and organ metastases were detected. T stage of patients presents as follows: 26 T4, T3B 29, T3A 40, T2 22 and T1 23 (bilateral tumours-7 patients). Patients were divided into groups: I-only nephrectomized (15), II-nephrectomized with adjuvant immunotherapy (ICHTH) (18), III-renal artery embolisation with subsequent nephrectomy (24), IV-renal artery embolisation with subsequent nephrectomy and adjuvant ICHTH (21), V-only palliative embolisation of renal artery (60).

Results: The mean observation time was 25.4 months (1.5–145). 76 patients (55.1 %) died. Tumour dependent survival time was 14.25 m. (1–145). Progression of the disease was observed after 10.9 months (1 m–11 years). Observation time, progression free survival time and tumour dependant survival time counted: Group I-observation time 20.1 months (3.9–56.1), progression time 5.3 months (2.4–25.3), tumour dependant survival time 10.4 months (3.9–25.3), Group II-observation time 22.4 months (3–62.7), progression time 10.8 months (1 to 48.7), tumour dependant survival time 18.2 months (3 to 44.9). Group III-observation time 22.8 months (1.5–85.8), progression time 6.6 months (1–18.3), tumour dependant survival 9.1 months (2.2–24.2), Group IV-observation time 28.6 months (7.8–76.8), progression time 8.5 months (1–25.2), tumour dependant survival 26 months (7.8–76.8), Group V-observation time 11 months (1–53.5), progression time 8 months (1–30). Observation results were compared to data from the literature relating the patients survival with metastatic RCC (6 m mean).

Conclusions: 1. Multidisciplinary MRCC treatment including: renal artery embolisation, subsequent nephrectomy and the adjuvant ICHT may lengthen the tumour dependant survival time. 2. Palliative embolisation of renal artery may slightly lengthen survival time of MRCC patients in comparison to symptomatic treatment. 3. Significantly longer survival time may be reached for good general condition patients (WHO 1–2). 4. Over 3 year observation time in some patients treated only by renal artery embolisation, without essential deterioration of their general condition, suggests nephrectomy reconsideration in certain cases.