Conclusions: PCT-RPLA remains critical in the management of pts with NSTT. Pts found to have T at PCT-RPLA have a probability for recurrence of 81%. The size of RM, worse histology and IGCCG risk classification were predictors of ds recurrence.

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Comparison of local anaesthetic effects of tramadol with prilocaine during circumcision procedure

E. Kargi[1], A. Isıkdemir[1], H. Tokgoz[2], B. Erol[2]*, F. Isıkdemir[1], V. Hanci[2], C. Payasli[1]. *[1]Karaelmas University, Dept. of Plastic and Reconstructive Surgery, Zonguldak, Turkey; [2]Karaelmas University, Dept. of Urology, Zonguldak, Turkey*

Introduction and Objectives: Recently, it has been shown that tramadol was an effective local anaesthetic in minor surgery. The aim of this study was to compare the local anaesthetic effects of tramadol hydrochloride with prilocaine for circumcision procedure.
Material and Methods: This article was planned with 40 ASA-I patients undergoing circumcision for religious belief. Patients were randomly allocated to receive either 5% tramadol (2 mg/kg) plus adrenaline (0.0125/cc) (Group 1, n = 20) or 2% prilocaine plus adrenaline (0.0125/cc) (Group 2, n = 20). Both were infiltrated intradermally in a circumferential pattern and in a double-blinded fashion. The degree of the burning sensation and pain at the injection site were documented. Sensory block was assessed 1 min after injection and they were asked to grade touch and pinprick sensation. Five minutes after drug administration, incision was performed and intensity of pain, felt by the patient was evaluated on a four-point scale (0–3). Injection site pain and local skin reactions were also recorded.
Results: Mean ages were 9.7 and 10.3 years for Groups 1 and 2, respectively. Mean duration of surgery was 19.6 minutes. Throughout the operation and in early postoperative period, no local or systemic adverse effect was observed. All children were discharged on same day. After 24 hrs, patients were invited for control. In control visit, 2 out of 20 (10%) in Group 1, and 10 out of 20 (50%) children in Group 2, reported extra need for oral Ibuprofen ($p < 0.05$). First analgesic medication time was 9.5 ($\pm$2.1) hours (hrs) in group 1, and 8.7 ($\pm$3.1) hrs in Group 2 ($p > 0.05$). Total postoperative Ibuprofen consumptions were 10 and 50 miligrams for Group 1 and 2, respectively ($p < 0.05$).
Conclusions: A combination of tramadol 5% plus adrenaline can provide a safe and effective local anaesthesia during circumcision procedure and postoperative period in children.

N83

High risk clinical stage A nonseminomatous testicular tumors: Primary retroperitoneal lymphadenectomy or cisplatin-based chemotherapy?

D. Argirovic[1]*, A. Argirovic[2]. *[1]Clinic of Urology, Outpatient Clinic Argirovic, Urology, Belgrade, Serbia; [2]CHC Zemun, Urology, Belgrade, Serbia*

Introduction and Objectives: It was previously reported that the patients (pts) in clinical stage A (CS-A) nonseminomatous testicular tumors (NSTT) were more likely to relapse if they have >50% embryonal carcinoma (EC) and microvascular tumor invasion (VI+), The aim of this study is to report the value of retroperitoneal lympadenectomy (RPLA) vs cisplatin (CDDP)-based chemotherapy (CT) in high risk (HR) NSTT with normal values of serum tumor markers (STM) postorchiectomy.
Material and Methods: 138 pts entered a prospective but non-randomized study from 1980 to 2005. The pts are divided into 2 groups according to applied primary treatment. Arm A (n = 60): RPLA with 2 cycles of CDDP-based CT in PS-B1/B2 and Arm B (n = 78): only 2 cycles of CDDP-based CT following orchiectomy [PVB (n = 15), PEB (n = 63)]. Pts characteristics were stratified according to primary treatment: 70%, 59% were >50% EC. 45%. 64% were VI+ and 22%, 26% were >50% EC with VI+, respectively.
Results: Arm A – relapses occurred in 10 pts (17%) (7/46 (15%) in PS-A and 3/14 (21%) in PS-B1/B2 within median free interval (MFI) of 8.3 months (m) (range 2–3)(lung5, RPLN 1, only elevated STM 1) and 51.3 m (range 8–12o) (RPLN 1, only elevated STM 2) with survival in 95% and 86%, respectively). 21 pts (35%) received postop CDDP-based CT (7 in relapse in PS-A and 14 due to LN metastasis). Overall, alive and free of disease (AFD) are 55 pts (9%) ate median follow-up (MFU) of 14.5 years (y) (range 10.8–16.3) (1 pt died of other malignancy at 90 m). There were 11 surgical complications in 6 pts (10%), 2 minor and 9 major complications. Ejaculatory disturbances occurred in 12 pts (20%) Arm B – 2 pts (2.6%) relapsed within MFI of 8 m (9.7) (lung 1, RPLN+lung 1). Both relapsing pts underwent salvage CT+lung sugery with finding of viable GCT, 1 pt died at 18 m. AFD are 77 pts (9%) at MFU of 8.5 y (range 4–17.6). Hematologic toxicity was mild: 11 G3 and 8 G4 with 4 episodes of febrile neutropenia among 125 treatment cycles according to PEB regimen. 2 G3 and 6 G4 neutropenia ocurred in pts treated by PVB regimens. 2 pts presented tinnitus. The comparison of the results between Arm A and B demonstrated significant difference of RR ($p < 0.0036$) and DSS ($p < 0.0416$) in favor of Arm B.
Conclusions: Pts with HR CS-A NSTT are not necessarily helped by initial RPLA, except to secure the RP and make diagnosis and treatment of relapse potentially easier, but at what price? According to our experience 2 cycles of CDDP-based CT following orchiectomy constitute the treatment of choice with acceptable toxicity. However, optimum therapy has not yet been defined, and we are currently evaluating a regimen with only 1 course of CDDP-based CT following orchiectomy.

N84

Extremely low occurrence of late events following adjuvant carboplatin chemotherapy for clinical stage A seminomatous testicular tumors

D. Argirovic[1]*, A. Argirovic[2]. *[1]Clinic of Urology, Outpatient Clinic Argirovic, Urology, Belgrade, Serbia; [2]KBC Zemun, Urology, Belgrade, Serbia*

Introduction and Objectives: Radiotherapy (Rtx) has been the standard treatment of patients (pts) with clinical stage A (CS-A) seminomatous testicular tumors (STT) for decades. Carboplatin (CBDCA) has been advocated as an effective treatment alternative to avoid well known late effects of Rtx (2nd cancer, gastrointestinal and cardiovascular toxicity) and the high recurrence rate of surveillance. Since CBDCA chemotherapy (CT) was initiated more than 18 years ago, we evaluated the long term oncologic effectiveness and morbidity.
Material and Methods: Between 1982 and 2005, 230 pts received adjuvant single-agents CBDCA CT (400 mg/sqm/q 3 weeks), 2–3 weeks after radical orchiectomy: 222 pts received 2 cycles and 8 pts with persistently elevated hCG post-orchiectomy 3–4 cycles. In all pts CT could be performed on outpatient basis during 2 h.
Results: 6 pts (2.7%) relapsed within median free interval (MFI) of 13.8 months (m) (range 4–34) (RPLN 5, only elevated hCG 1), including 2 late relapses at 28 and 34 m. All relapsing pts achieved CR with cisplatin-based CT. Among 476 treatment cycles no life treating toxicity was observed. Mild gastrointestinal discomfort occurred in 40 pts (17.4%). Myelosupression was minimal with none pts demonstrated leucopenia or thrombocytopenia gr. II-III. CBDCA CT was not associated with alopecia, renal, neuro or ototoxicity. Metachronous GCT occurred in 4 pts (1.7%) within MFI of 20.2 m (range 4–36) (3pts had discordant histology, organ preserved

operation is performed in 3 pts, surveillance in 3 pts). At median follow-up of 7 years (y) (range 3–13) (38 >10 y, 138 >5 y) disease specific survival is 100%, 1 pt (0.4%) died from lung cancer at 28 m and 1 pt (0.4%) of cardiovascular disorders at 45 m.

Conclusions: Long term results confirm early reports – in CS-A STT 2 cycles of CBDCA CT were found highly effective from an oncologic standpoint and associated with only minimal morbidity.

N85
Surgical treatment of hypererectio

J.E. Baginska*, W. Piaskowski, K. Krajka. *Medical University, Dept. of Urology, Gdańsk, Poland*

Introduction and Objectives: The angle formed by the axis of the penis and abdominal surface is called an angle of erection. Initially, it is around 45 degree, gradually with age, rising to an angle of 90 degree. In this way, oblique position of the penis is similar to the axis of the vagina and naturally facilitates its penetration. The available literature did not give the description at of the situation in which the low angle of erection would impede normal intercourse and forced affected by this anomaly to seek for help urologist. Horizontal stability during erection is provided by an extremely strong concrescence corpores cavernoses and pubic bones. Axial stability is given by the ligaments. The intersection of those ligaments is a part of the operation of extending penis (Burman's method). The adverse effects are the increased angle of erection and the risk of loss stability of penis. The aim of this paper is to present the procedure for correction "hypererection" and the discussion of the possibilities of treatment probably not rare anomaly that makes sexual life difficult or impossible.

Material and Methods: Over the past three years in the Department of Urology of Medical Academy in Gdansk we have reported three men complaining too little angle of erection (the penis significantly close to abdominal wall). It make sexual relations impossible. Problems consisted of difficulties in the penetration of vagina and pain during the intercourse reported by both partners. Using the experiences learned from mentioned "penis extension" sick were proposed intersection the ligaments of penis anticipating about possible adverse consequences In subarachnoid anesthesia by semi-circle, 6–7 cm long cutting we reached the base of the penis and the surface and pubic symphisis. We intersected the ligaments. We separated the 4 cm base of the penis. Into created space we temporarily inserted Redon's drain.

Results: The first patient, KT 24 years, resident of Lublin, gave the information by telephone that he is satisfied with the effect of the operation and refused to control. Since this was the first case of this condition we did not ensure preoperative documentation. Patient, GP 19 years, is satisfied of effect. During clinic control in spite of visual stimulation did not achieve a full erection. Then he changed the address because he begun study. Patient, MO 32 years, married, is satisfied with the result of surgery. We have photographic documentation before and after surgery. We also present photos of his surgical treatment.

Conclusions: When examining the three reported cases, we believe that correcting surgery should be performed at pharmacologically caused erection. Midoperationaly assessment of the possibility of increasing the angle of erection better control treatment and help to avoid the risk of loss stability of penis.

N86
Hereditary behavior of varicocele

A. Gökçe[1]*, M. Davarcı[1], F.R. Yalçınkaya[1], E.O. Güven[1], Y.S. Kaya[1], M.R. Helvacı[2], M.D. Balbay[2]. [1]*Mustafa Kemal University Tayfur Ata Sökmen Medical School, Dept. of Urology, Hatay, Turkey;* [2]*Mustafa Kemal University Tayfur Ata Sökmen Medical School, Dept. of Internal Medicine, Hatay, Turkey*

Introduction and Objectives: We examined the first-degree relatives of men with known varicocele to reveal the familial risk for varicocele.

Material and Methods: This study consisted of two phases: a retrospective review of patient charts and prospective physical examination and collection of data. In the first phase, all charts of patients with clinical varicocele who presented with infertility, testicular pain, or aesthetic problems between June 2008 and May 2009 were reviewed. Of the 113 patients, 49 (43.4%) agreed to have their available first-degree relatives contacted for screening of varicoceles. Of the 92 first-degree relatives contacted, 66 (71.7%) decided to participate in this study. In the second phase, all first-degree relatives included in this study were examined for varicocele and data collcted. All first-degree relatives were asymptomatic and had neither a history of infertility nor a prior diagnosis of a varicocele.A cohort of 100 consecutive men who applied to the department of internal medicine for check up procedure without a history of subfertility or a varicocele were used as a control population. All men in the control group had undergone an equal detailed physical examination by the same urologist as the study population. The severity of varicoceles have been classified according to standard grading system. The chi-squared test was used to compare the prevalence of varicoceles in our first-degree relatives and our control group.

Results: Past medical history revealed that none of the first-degree relatives of patients had surgery for varicocele or retroperitoneal disease which may affect gonadal veins. Of the 66 first-degree relatives, 21 (33.9%) had a palpable varicocele on physical examination. Among these men, 4 (21.1%) of 19 fathers and 17 (36.2%) of 47 brothers had palpable varicocele. Eighteen men had a unilateral left varicocele and 3 bilaterally palpable varicoceles. Of the 100 men used as a control group, 12 (12%) had a palpable varicocele on physical examination. Of the 12 patients, 8 had a unilateral left varicocele and 4 bilaterally palpable varicoceles. Compared with control population (12%), the prevalence of palpable varicocele in the first-degree relatives of patients with known varicocele (33.9%) was approximately 3-fold higher ($P < 0.005$) (Table 1).

Conclusions: A significant increase in varicocele prevalence is present in the first-degree relatives of men with known varicoceles. Patients should be counseled about this increased risk in male relatives of patients.

Table 1. Properties of patients, first-degree relatives, and the control group

	No. (n)	Varicocele (%)	Unilateral n (%) (left/right)	Bilateral n (%)	Grading of Varicoceles		
					Grade 1 n (%)	Grade 2 n (%)	Grade 3 n (%)
Patients	49	49/49 (100%)	43 (87.8) (43/0)	6 (12.2%)	3 (5.5)	17 (30.9)	35 (63.6)
First-degree relatives	66	21/66 (33.9%)*	18 (85.7) (18/0)	3 (14.3%)	7 (29.2)	8 (33.3)	9 (37.5)
Control	100	12/100 (12%)	8 (72.7) (8/0)	4 (27.2%)	2 (12.5)	6 (37.5)	8 (50)

* $p < 0.005$ compared with control group