

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.

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Surgical treatment of hypererectio

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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 condescence 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 "hypererectio" 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 symphysis. 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.

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Hereditary behavior of varicocele

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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 collected. 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. Varicocele (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