Material and Methods: For the period of 5 years in the clinic of pediatric urology in the University Hospital Pirogov 12 feminizing reconstructions of the external genitalia were performed in children at the age between 1 and 14. We offer our method of feminizing reconstruction, which consists of:
- resection of the clitoris
- opening of introitus vaginae
- plastic reconstruction of the external genitalia – labii minoris and preputium clitoridis.

According to the size of the clitoris we performed:
- resection with termino-terminal anastomosis of the cavernous body of the clitoris, preserving the neurovascular body in the cases with smaller clitoris
- resection of the body of the clitoris, preserving part of glans clitoridis on a neurovascular body.

Results: we follow up the early and late results by means physical examination and photo documentation. The late results in all operated children are with good cosmetic result and preserved sensitivity of glans clitoridis.
Conclusions: we recommend our organ sparing method of choice for operation and tactic of treatment for the feminizing reconstruction in children.

S123

One stage metoidioplasty in female to male transgender patients: the role of genital flaps for urethral reconstruction

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Introduction and Objectives: Urethral reconstruction presents one of the most complex surgical procedures in metoidioplasty. We appraised the role of local vascularized genital flaps (vaginal wall, clitoral and labial skin) in urethral reconstruction as a part of one stage metoidioplasty.
Material and Methods: Total of 112 patients underwent metoidioplasty from August 2003 to February 2009. Urethral reconstruction consists of two parts: (I) creation of proximal part of the neourethra by joining of the flap formed from anterior vaginal wall and proximal part of divided urethral plate, (II) reconstruction of distal part of neourethra using different genital local flaps; in 21 cases longitudinal island clitoral skin flap was button-holed ventrally and tubularized (group 1); combined buccal mucosa graft and dorsal island skin flap was used in 33 patients (group 2), while in remaining 58 patients combined buccal mucosa graft and labia minora skin flap was used for urethral reconstruction (group 3). One stage metoidioplasty was done as previously reported.
Results: The mean follow up was 37.5 months (range 4–71 months). All patients reported voiding while standing. Comparing these different types of urethral reconstruction, better results are achieved in groups with combined buccal mucosa graft and vascularized genital flaps, especially labia minora flap, where success rate was 92%. In this group of patients fistula occured in 4 patients and was resolved three months later by minor surgical procedure. One patient had distal urethral stricture which was resolved by simple dialation.
Conclusions: Urethral reconstruction in female to male transsexuals, undergoing metoidioplasty as one stage surgical procedure, relies on appropriate and versatile use of different genital flaps. Permanent improvement in technique and results are needed for minimal complication rate. Combination of buccal mucosa graft and labia minora skin flap presents the most successful alternative for urethral reconstruction in these patients.

S124

Combined total phalloplasty and metoidioplasty as a single stage procedure in female to male gender reassignment surgery

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Introduction and Objectives: Total phalloplasty includes creation of neophallus from an extragenital tissue, large enough to enable insertion of penile prosthesis and penetration during sexual intercourse. Urethroplasty, which enables voiding in standing position, is performed later on, in separate stages. Metoidioplasty presents creation of small phallus, from hormonally enlarged clitoris, which enables voiding in standing position, but without possibility for sexual intercourse. We evaluated advantages of combining phalloplasty and metoidioplasty as one stage procedure.
Material and Methods: Between May 2007 and June 2008, five female transsexuals, aged 26–42 years (mean 35 years) underwent one stage phalloplasty combined with metoidioplasty. Surgery included: removal of internal/external female genitalia, creation of neophallus using microvascular latissimus dorsi free flap, clitoral incorporation into the neophallus, urethral lengthening and insertion of testicle prosthesis into the scrotum created from joined labia majora. Penile prosthesis insertion is planned for the next stage.
Results: Follow-up was from 11 to 21 months (mean 15 months). The length of neophallus ranged from 14–17 cm with circumference from 12–15 cm. There was no partial or total necrosis of the phallus. All patients obtained voiding in standing position. Urethral fistula occurred in one case and repaired 3 months later.
Conclusions: Combined total phalloplasty and metoidioplasty is feasible and safe surgical procedure. The main advantage is complete reconstruction of neophallus that avoids multi-staged gender reassignment procedures in female to male transsexuals. Our results confirmed successful outcome.

S125

Functional and esthetic reduction of hyperthrophied labia minora

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Introduction and Objectives: Hypertrophied labia minora can be functional or psychosexual problem. Local irritation, hygiene problems, difficulties during sexual intercourse as well as aesthetical appearance are generally accepted as indications for surgical correction. We present our results in the reconstruction of hypertrophied labia minora.
Material and Methods: Between May 2004 and January 2009, 19 women, aged 18 to 36 years (median 21) underwent surgical correction of hypertrophied labia minora. The majority of the patients (17/19) were dissatisfied with the appearance of their labia. Two patients presented pseudo incontinence due to urinary retention in vulvar and vaginal space. Excessive parts of both labia minora are removed including part of the clitoral hood to reach better esthetical appearance. The desired length of the labia minora is preoperatively discussed with the patient and the difference between the levels of the labia minora and labia majora is kept to be no less than 1 cm. The wound is sutured using running 6–0 resorbable suture. Compression dressing is applied for the first week to prevent swelling and haematoma.
Results: Follow-up ranged from 6–61 months (median 28 months). Good esthetic results with symmetrical reduced labia are achieved in all patients. In two patients with

pseudo incontinence, there was no more urine leakage from vulvar region. There was neither haematoma nor infection postoperatively.
Conclusions: Reduction of hypertrophied labia minora is simple and safe procedure and restores the natural rounded contour of the edge of the labia minora. It should be considered for cases in which functional and esthetical reasons could be resolved by this technique.

S126
Our experience in treating 27 genito-urinary fistulas during 2002–2008 in regional Shkodra hospital, Albania

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Introduction and Objectives: To study the etiology and therapeutic aspect of genito-urinary fistulas in the population of North of Albania.
Material and Methods: This is a retrospective study analysis the genito-urinary fistulas in our hospital during years 2002–2008. The main outcomes analyzed for 27 patients were etiology, surgical approaches, needs for tissue interposition and cure rate.
Results: We treated 27 patients, 16 patients as a consequence of difficult hysterectomy, 7 patients because of obstructed labor, 2 patients as a result of trauma and 2 patients because of irradiation. In 60% of cases we realized via transvaginal using Martiuz flap. In one of these cases with total missing of urethral wall we used the TVT to control postoperative incontinence. In other cases we used transabdominal approach using omental flap. In one case of uretero-vaginal fistula we dissected the ureter from vagina, repaired both organs and protected the suture line to ureter with a J stent. The total success rate was 85%.
Conclusions: Genito-urinary fistulas as a social debilitating condition needs surgical treatment. In our society most of cases comes as a consequence of gynecologic surgery, but there are still cases as a result of obstructed labor. The % of repair is reasonably good 85%.

S127
Hanged ventral buccal mucosa graft in the treatment of urethral stricture after failed hypospadias repair

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Introduction and Objectives: Urethral stricture is one of the common complications after severe hypospadias repair. Usually, two or more procedures are needed to its correction due to a lack of available material after previous repair. We present one stage urethral reconstruction by ventral placement of buccal mucosa graft and emphasize necessity for its hanging to periurethral tissue.
Material and Methods: In period from August 2002 to September 2008, 13 patients, aged 9 to 32 years, underwent urethral stricture repair after failed hypospadias surgery. Stricture was opened ventrally and properly sized buccal mucosa graft was placed to augment urethral lumen. Graft was hanged on surrounding urethral tissue by several U sutures. This way, good covering of the graft and prevention of its folding with retraction were achieved. Associate chordee (10 patients) and secondary vesicoureteral reflux (3) were corrected simultaneously.
Results: Mean follow-up was 36 (8–71) months. A successful result was confirmed in all patients by urethrography and uroflowmetry. One urethral fistula was corrected three months later. Recurvation did not occur in this group. There was no recurrence of the reflux in endoscopically treated patients.
Conclusions: Hanged ventral buccal mucosa graft presents simple and safe variant for urethral stricture repair. Proper anchoring of the graft is very important for its survival and prevention of folding with retraction.

S128
Reconstructive urethral surgery for residual hypospadias and/or complications after failed hypospadias repair in childhood

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Introduction and Objectives: To evaluate retrospectively our results in urethral reconstruction in teenager and adults with persistent hypospadias and/or complications after multiple failed hypospadias repaire in childhood.
Material and Methods: Between Octobre 1999 and February 2008, 40 patients (p) underwent reconstructive surgery for persistent hypospadias and/or complications after failed hypospadias repaire in childhood.Mean age was 30.45 years (18–72 years).The reason for presentation was: stricture (8p), fistula (8p),stricture and fistula (7p), residual hypospadias (6p), residual hypospadias and penile curvature (4p), residual hypospadias and stricture (1p), residual hypospadias and fistula (1p), residual hypospadias, penile curvature and hair (1p), stricture and penile curvature (1p), stricture fistula and penile curvature (1p), stricture and stone on the hair (1p), stricture and diverticula (1p).We have performed 27 one-stage urethroplasty:bucal mucos graft (3p), flaps (13p), Snodgrass (5p), combinations urethroplasty (6p), and 13 two stage urethroplasty:simple with buccal mucosa graft (10p)or preputial skin graft (1p) and combination urethroplasty (2p).
Results: 19p/40p (47.50%) had complications:fistula (13p), dehiscence of glans (4p), dehiscence of neourethra (1p) and fibrous diafragm (1p). 21p/40p (52.50%) had a final successful outcome, with a mean follow-up of 37.62 month (7–107 month). The same good outcome had 11p/40p (27.50%) reoperated for complications, the rate of succes on long follow up raising to 80%.
Conclusions: The operations for this iatrogenic urethral pathology have a high rate of complications (47.50%) and reoperations (27.50%), demanding specific type of urethroplasty for each particular case. The choice mast be done on the basis of general urethral reconstructions ruls, filtered through personal experience of the urologist, to achive at the end the goals of hypospadias surgery.The performance of each type of urethroplasty demands vaste experience in this field, and the urologist involved in this type of urethral reconstructive surgery must be familiar to all urethroplasty.Before surgery the patient must be informed about the the possible complications and reoparations, necessary to obtain at the end a good functional and resonable aesthetic result.

S129
Treatment of proximal hypospadias using extended snodgrass technique with dorsal dartos flap wraping

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Introduction and Objectives: Since Fistula formation is the most common complication with various rates, we evaluated the importance of a urethral covering using long vascularized dorsal subcutaneous tissue for fistula prevention, Snodgrass technique, for correction of proximal hypospadias.
Material and Methods: During the period from April 2004 through November 2008 we evaluated 16 patients aged