have a lot of other medical problems therefore ED does not present such a problem for diabetic patient.

C45

Cross-sectional, controlled epidemiological study investigating erectile dysfunction and late onset hypogonadism in leprosy patients

H. Guler, M.S. Silay*, M. Kadihasanoglu, O. Tanriverdi, M. Aydın, C. Miroglu, M. Kendirci. *Sisli Etfal Training and Research Hospital, 2nd Dept. of Urology, Istanbul, Turkey*

Introduction and Objectives: We aimed to determine the prevalence and associates of erectile dysfunction (ED) and late onset hypogonadism (LOH) in men with leprosy.
Material and Methods: A total of 106 men (51 leprosy and 55 healthy control) were included into the study. All subjects were evaluated by detailed medical and sexual history and focused physical exam including measurements of testicular volumes with orchidometer. IIEF, AMS-SF and BDI were were used to assess sexual functions, LOH symptoms, and psychogenic status, respectively. Blood samples were drawn at 08–11 a.m. to measure the hormonal and biochemical status. All variables were compared statistically between the groups using chi-square, t, and Mann-Whitney U tests where appropriate. $p < 0.05$ was considered as statistically significant.
Results: Mean age was similar in both groups (58.39 ± 10.51 vs 56.58 ± 8.05 years, $p = 0.320$). The mean IIEF score in the leprosy group was significantly lower than controls (13.53 ± 10.90 vs 24.27 ± 7.45, $p < 0.001$). All domains of the IIEF except desire revealed significantly worse scores in leprosy patients ($p < 0.001$). Besides, the AMS-SF scores in the leprosy group were significantly increased compared to control (33.69 ± 8.97 vs 25.85 ± 5.71, $p < 0.0001$). Mean testicular volumes measured with orchidometer were significantly reduced in the leprosy men compared to control ($p < 0.0001$). Calculated bioavailable testosterone values were also found to be significantly decreased in the leprosy group compared with the control group ($p < 0.0001$).
Conclusions: This prospective, cross-sectional, controlled epidemiological study demonstrated the relationship between the leprosy disease and ED. In addition, we have showed increased rate of hypogonadal dysfunction in leprosy patients as evidenced by biochemical and clinical parameters.

C46

Transrectal ultrasonography of prostate, serum levels of PSA and testosterone and long term hormonal substitution therapy in patients with Kallmann syndrome

K. El Balouly[1]*, J. Heráček[2], M. Snajderova[3], D. Zemkova[3], F. Zatura[4], M. Urban[2]. *[1]1charles University In Prague, 3rd Faculty of Medicine, Dept. of Urology, Prague, Czech Republic; [2]Charles University In Prague, 3rd Faculty of Medicine, Dept. of Urology, Prague, Czech Republic; [3]Charles University In Prague, 2nd Faculty of Medicine, Dept. of Paediatrics, Prague, Czech Republic; [4]Palacky University, Dept. of Urology, Olomouc, Czech Republic*

Introduction and Objectives: Introduction: Kallmann syndrome is a very rare genetic disease characterized by hypogonadotropin hypogonadism. The aim of this work was evaluation of the transrectal ultrasonography of prostate, serum levels of PSA (prostate specific antigen) and testosterone in long term continuous hormonal substitution therapy.
Material and Methods: Material and Methods: Since 2001 were observed 9 patients in this study in age of 18–32 years with Kallmann syndrome, mean time was 4.8 years (6 months-8.3 years). Hormonal induction of puberty was initiated by hCG, followed by testosterone continuous substitution therapy (every 3 weeks Sustanon® 250 i.m. or every 3 months Nebido® i.m.). We evaluated transrectal ultrasonography of prostate and seminal vesicles with 3D reconstruction and serum levels of PSA and testosterone every 6 months.
Results: Results: No significant changes in the monitored parameters have been detected. The mean prostate volume was 8.7 (6.1–14.7) mL, mean serum level of PSA was 0.68 (0.25–0.89) μg/L and testosterone 10.8 (7.2–19.9) nmol/L. In one patient occured symptoms of depression related to testosterone substitution therapy.
Conclusions: Conclusions: This work presents the results of long term comprehensive care of patients with impaired sexual development. Long term monitoring of these patients in interdisciplinary cooperation of urologist and endocrinologist can help to clarify the impact of testosterone substitution therapy on the development and volume of prostate. Grant support: Internal Grant Agency of the Ministry of Health, No. NS9983.

C47

Salvage retroperitoneal lymphadenectomy after multiple chemotherapy regimens for nonseminomatous testicular tumors

D. Argirovic[1]*, A. Argirovic[2], V. Stanic[3]. *[1]Clinic of Urology, Outpatient Clinic Argirovic, Urology, Belgrade, Serbia; [2]CHC Zemun, Urology, Belgrade, Serbia; [3]Military Medical Academy, Thoracic Surgery, Belgrade, Serbia*

Introduction and Objectives: We reviewed our experience with retroperitoneal lymphadenectomy (RPLA) after multiple cisplatin (CDDP)-based chemotherapy (CT) regimens in nonseminomatous testicular tumors (NSTT) patients (pts) and specifically evaluated clinic-pathologic and treatment trend in addition to potential predictors of survival.
Material and Methods: 41 pts with NSTT underwent their RPLA between 1980 and 2005 after >2 regimens of CT. 13 pts (32%) necessitate redo-RPLA, combined with nephrectomy in pts. 13 extra-RP resections were performed in 11 pts (27%), including pulmonary (7), neck (4) and liver (2) sites.
Results: 30 pts (73%) are rendered grossly free of disease (ds) and 26 (63%) obtained serologic remission. 9 pts who relapsed within MFI of 28 months (m) (RPLN 8, RPLN+lung 1) necessitated CT+surgery (3 teratoma, 6 vital GCT). 4/9 relapsing pts (44%) are currently free of ds with redo-RPLA. Alive, free of ds are 19 pts (46%) at MFU of 131 m. Study of RP pathology demonstrated the presence of fibrosis in 15%, teratoma in 39% and vital GCT in 46%, with survival in 67%, 56%, and 32%, respectively. Worse vs favourable histology occurred in relation of 32% vs 59% ($p < 0.05$). Different histology occurred in 38% at redo-RPLA and in 64% at ERP resection in comparison to previous RP pathology ($p = 0.219$). Univariate analysis of clinico-pathologic parameters associated with vital GCT at RPLA included RP mass >5 cm ($p < 0.05$), elevated AFP ($p < 0.001$) or HCG ($p < 0.05$) and ERP resection ($p < 0.04$). On univariate analysis survival was worse in pts with RP masses >5 cm ($p < 0.04$), elevated AFP ($p < 0.05$) or HCG ($p < 0.007$), ERP resection ($p < 0.01$), and vital GCT ($p < 0.004$). On multivariable analysis, a RP mass >5 cm ($p < 0.03$) and vital GCT ($p < 0.005$) predicted a worse prognosis. Vital GCT either in the RP or in ERP sites predicted worse prognosis ($p = 0.001$).
Conclusions: Our data support the continued use of salvage RPLA in 3 separated groups of pts: 1. Pts who achieved a CR on 2nd line CT and have no radiologic evidence of ds should undergo RPLA; 2. Pts who achieved a PR to CT should undergo RPLA with ERP surgery, as indicated; 3. Highly selected pts with residual mass and elevated STM, particularly AFP, after CT may be candidates for surgery.