

C62**Comparative study regarding quality of life assessed by SF-36 health survey in older versus younger and related versus non-related live kidney donors**

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Introduction and Objectives: SF-36 Health Survey was designed to assess the health status in general. This study compared the quality of life (QOL) in four groups of kidney donors – related versus non-related live kidney donors and younger versus older donors. We defined the border age of 65 (retirement age in Romania) in order to compare the two age donor groups.

Material and Methods: From June 1997 until May 2009, 1000 kidney transplants (799 living and 201 cadaver, 949 adults and 51 pediatric) have been performed in our center, with an average of 83 /year (116 in 2007). In all cases, general preoperative evaluation, immunological and vascular anatomy study was performed. Standard minimal lombotomy nephrectomy technique was preferred. The SF36 evaluation was performed before surgery, one month and six months after surgery. One group of 65 young donors (mean age 43) was compared with a group of 40 older donors (mean age 67) and a group of 53 related donors were compared with a group of 53 unrelated donors using the QOL questionnaire.

Results: Eight scales of SF-36 health survey were scored in all four groups: physical functioning (PF), role physical functioning (RP), bodily pain (BP), general health (GH), vitality (VT), social functioning (SF), role emotional functioning (RE), and mental health (MH). Baseline QOL was better in younger versus older group. Summarizing the results, PF, RP, VT and GH were deteriorated after one month in older group ($p < 0.001-0.003$) and recovered close to baseline after six months. Bodily pain was worst in younger group one month and six months after surgery, while all the other scales recovered close to baseline. PF, RE and MH were deteriorated significantly in non related versus related donors after one month while BP, VT and SF follow the same returning in both groups. Six months after surgery non significant differences were detected.

Conclusions: QOL in non-related versus related donors returned at a baseline but following a slowly curve in the first group. Bodily pain scale in young donors recovered less effective than older donors while QOL in general return close to a baseline in older patients after six month following a slowly curve than younger donors. Considering that surgical results and graft function are comparable in all four groups, further expansion of borderline older donor pool is accepted.

C63**Early graft dysfunction due to vascular anomalies, vessels reconstruction and special anastomotic techniques in kidney transplantation**

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Introduction and Objectives: The aim of this study was to evaluate one week renal graft function consecutive to additional arterial and venous reconstruction and special anastomotic techniques during renal transplantation.

Material and Methods: 12 years transplant experience (June 1997 – May 2009) was assessed considering 1000 renal transplantations (799 living and 201 cadaver, 949 adults and 51

pediatric) with an average of 83 /year (116 in 2007). In all cases, general preoperative evaluation, immunological and vascular anatomy study was performed. 310 cases (31%) had vascular graft anomalies, 185 abnormal arteries and 125 abnormal veins.

Results: Special anastomotic and reconstruction techniques were used as followed: double T-T anastomosis – 111 cases, T-L anastomosis – 10 cases (cadaver donors), combined anastomosis – 3 cases; single trunk made by two branches – 31 cases and we used the epigastric artery for small branches in 4 cases. Minor aberrant vessels were excluded, feeding a minor area of parenchyma. Cava patch and venous reconstruction were used in 41 cases (21 from cadaver donors). Abnormal venous drainage was managed by classical T-L anastomosis to the external iliac vein. One week vascular graft failure occurred in 1.4% cases – one arterial reconstructed graft (0.6%) and one venous reconstructed pedicle (0.8%), proving a reasonable result.

Conclusions: Vascular anomalies of renal pedicle were founded in 31% but transplantation was performed due to special reconstruction and anastomotic techniques. Arterial and venous reconstruction combined with special anastomotic procedures did not increase the risk of early graft failure. One week graft function remained in very good condition. Accepting the borderline vascular donor, the number of transplantation could increase with 30%.

C64**The impact of slow and delayed graft function vs. immediate graft function on cadaver renal transplant outcomes**

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Introduction and Objectives: According to the initial graft function, kidney transplant patients could be divided into three groups: immediate graft function (IGF – postoperative day 5 serum creatinine < 3 mg/day), slow graft function (SGF – day 5 creatinine > 3 mg/dl, no dialysis) and delayed graft function (DGF – day 5 creatinine > 3 mg/dl and dialysis). Delayed graft function is a common complication in cadaver kidney transplants sometimes with an arbitrary definition. There is disagreement about the impact of slow and delayed graft function on renal transplant outcomes. Our study was designed to assess the impact of the above three categories in transplant outcomes, and factors involved in first days graft function such as donor age and additional vascular reconstruction.

Material and Methods: From June 1997 until May 2009, 1000 renal transplantations (799 living and 201 cadaver, 949 adults and 51 pediatric transplants) with an average of 83 /year (116 in 2007), were performed in our center. 86 cadaver transplants entered in our study and renal grafts developed function as follows: 61 transplants were IGF, 17 were SGF and 8 DGF. Acute rejection episodes (AR), serum creatinine level and graft survival were analyzed three months, six month and one year after surgery. Young donors and old donors (the edge of 60), normal pedicle and reconstructed pedicle were considered.

Results: SGF patients showed worse results considering acute rejection, creatinine level and graft survival in comparison with IGF but better than DGF group. Donor age and additional vascular reconstruction did not significantly modify the outcomes. One year graft survival was better in IGF group than other two groups. Creatinine was worse in SGF group than IGF group – 1.8 ± 0.8 mg/dl vs. 1.4 ± 0.5 mg/dl, but better than DGF group – 2.1 ± 0.6 mg/dl at 12 months, AR rate was 20% (12) in IGF group, 35.2% (6) in SGF group and 50% (4) in DGF group.

Conclusions: Slow graft function has to be considered in appreciation of graft dysfunction. Patients developing SGF have

a worse outcome than patients with IGF but similar, or in special cases better than patients developing DGF. Despite they did not need dialysis, SGF patients show worse creatinine level and graft survival and higher acute rejection than IGF. Even mild to moderate post-transplant dysfunction can have a negative impact in graft function and survival.

C65

Preoperative evaluation, management and surgical approach in non conventional kidney transplantation due to graft vascular anomalies – 12 years single center experience

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Introduction and Objectives: 12 years transplant experience, using normal and abnormal renal pedicle, preoperative evaluation and special anastomotic techniques represented the aim of this study.

Material and Methods: From June 1997 until May 2009, 1000 renal transplantations (799 living and 201 cadaver, 949 adults and 51 pediatric transplants) with an average of 83 /year (116 in 2007), were performed in our center. General preoperative evaluation, immunological and vascular anatomy study and standard minimal lumbotomy nephrectomy were performed in all living donor transplant. 310 cases (31%) had vascular graft anomalies, 185 abnormal arteries and 125 abnormal veins.

Results: No major complications appeared in 799 nephrectomies. Minor complications were: renal artery spasm, bleeding, minor respiratory complication, pneumothorax, ileus, bladder voiding problems, UTI. Long-term complications were: persistent wound pain, paresthesia and wound hernia. Quality of life after surgery was assessed using SF 36 Health Survey Test and it was normal. Surgical approach to vascular anomalies were: double T-T anastomosis – 111 cases, T-L anastomosis – 10 cases (cadaver donors), combined anastomosis T-T and T-L – 3 cases; single trunk made by two branches – 31 cases and we used the epigastric artery in 4 cases. Minor aberrant vessels were excluded in 26 cases, feeding a minor area of parenchyma. Cava patch was used in 41 cases (21 from cadaver donors). Abnormal venous drainage was managed by classical T-L anastomosis to the external iliac vein.

Conclusions: Renal pedicle assessment, general and immunological evaluation, represented a must. No major complication appeared in living donor nephrectomy, mortality was 0. It respects in our center the international accepted morbidity. Vascular renal graft anomalies were discovered in 31% but transplantation was performed due to special anastomotic techniques which did not significantly increase the ischemia time and vascular complications. Accepting non optimal vascular donor, number of renal transplants could increase with 30%.

C66

Our experience with bladder cancer in patients after kidney transplantation

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Introduction and Objectives: The aim of this study is to present our experience with bladder cancer in patients after successful renal transplantation.

Material and Methods: We reviewed 10 cases of bladder cancer in our centre between 2002 and 2008. All patients used immunosuppressive therapy based on calcineurin inhibitors. The

average follow up was 43 months (9–72). 6 patients were men, 4 women. Average age at the time of diagnosis was 62 years (34–77). Average time after renal transplantation was 51 months (26–123). All the patients had first kidney transplantation, all grafts were cadaveric. We reviewed pathologic stage, histologic nuclear grade, progression and recurrence of superficial tumours. We also reviewed therapeutic approaches.

Results: In 8 cases (70%) we proved superficial bladder cancer (<pT1). In 2 cases (20%) we proved muscle-invasive bladder cancer (pT2). Histological nuclear grade of tumours was in 3 cases (30%) grade I, in 4 cases grade II and in 3 cases grade III. After transurethral resection of bladder tumour (TURB), we did not prove progression of the tumours, in 2 cases we proved down-stage of tumour (pT2 to pT1). We proved recurrence in 9 cases (90%). In all recurrent cases we proved recurrent disease 3 month after primal resection. No patient of our study died of bladder cancer. We did not prove any metastatic disease in our patients. The therapeutic approach was in all cases in first step TURB. After positive follow up cystoscopic evaluation 3 month after primal TURB, we used single-shot intravesical chemotherapy. We did not make any changes in immunosuppressive protocol.

Conclusions: Bladder cancer is uncommon complication after kidney transplantation. In therapy of superficial bladder cancer is not necessary to change immunosuppressive protocol nor perform extensive surgical procedures.

Poster session 5: Nephrolithiasis

Friday, 23 October 2009, 14:30–16:30

Poster room 2

C67

Ureteroscopic instrument damage; experience after 5,500 ureteroscopies

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Introduction and Objectives: Damage of the endoscopes or accessory instruments during ureteroscopy as well as other endourological interventions represents an intraoperative incident sometimes imposing the termination of the procedure or supplementary maneuvers for endoscopic removal. Our study aimed to review such incidents after a significant experience.

Material and Methods: Between June 1994 and February 2009, 5102 patients underwent retrograde ureteroscopy (5534 ureteroscopic procedures). Retrograde flexible ureteroscopy was performed in 173 cases, while 5361 procedures were performed using the semirigid ureteroscope. The instrumental damage encountered during all these procedures was reviewed.

Results: Severe damages to the endoscopes requiring their replacement was encountered in 6 cases (0.1%): deterioration of the optical system (1 case) and complete breakage (1 case) of the semirigid 10F ureteroscopes, respectively deterioration of the outer sheath (1 case), perforation of the working channel (1 case) and breakage of the majority of fibers composing the optical system (2 cases) of the flexible ureteroscopes. Damage of the accessory instruments occurred in other 18 cases (0.3%): basket fracture (5 cases, 1 for impacted calculus release), grasping extractors' breakage (4 cases), balloon dilator tearing (1 case), guidewire fracture (4 cases) and lithotripsy probes breakage (4 cases). 10 of these cases necessitated active removal maneuvers of the foreign bodies (parts of accessory instruments).

Conclusions: Instrumental damage during ureteroscopic procedures is not a very frequent intraoperative incident in