

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.

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### Poster session 5: Nephrolithiasis

Friday, 23 October 2009, 14:30–16:30

#### Poster room 2

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### 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

a center with high experience in this field. However, analysis of these cases is crucial in order to avoid future similar accidents.

#### C68

##### **Migrated and calcified ureteral stents: A challenging problem (experience on 125 cases)**

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**Introduction and Objectives:** The management of calcified or migrated ureteral stents may be a complex and difficult task. This study aimed to evaluate the efficacy of the endoscopic treatment in these cases.

**Material and Methods:** Between January 2000 and January 2009, we treated 67 patients with calcified stents (Group I) and 58 patients with migrated ureteral stents (Group II). Group I consisted of 34 cases with inferior loop calcification, 13 cases with superior loop calcification, 9 cases with both inferior and superior loop calcification, 8 cases with calcification of the ureteral segment, 3 cases with calcification of the entire stent length. The average stenting time was 14.6 months (range 3–36 months). Group II consisted in 52 cases with the distal loop ascended into the ureter and 6 cases with the stents completely migrated into the pyelocaliceal system.

**Results:** In Group I, we performed vesical ballistic lithotripsy (34 cases, 100% success), percutaneous nephrolithotomy (13 cases, 92.3% success), vesical ballistic lithotripsy and percutaneous nephrolithotomy (9 cases, 100% success), ureteroscopic lithotripsy (8 cases, 87.5% success), vesical ballistic lithotripsy, ureteroscopy and percutaneous nephrolithotomy (3 cases, 100% success). In Group II, we performed retrograde ureteroscopic extraction in 57 cases. In one case with a stent ascended superjacent to a neoplastic extrinsic ureteral stenosis, impassable in a retrograde fashion, we performed minipercutaneous stent's extraction using a semirigid ureteroscope antegradely inserted.

**Conclusions:** Calcified or migrated stents may be successfully managed using endoscopic techniques. Combined retrograde and antegrade endourological approach is often necessary, sometimes requiring advanced endoscopic skills.

#### C69

##### **Ureteroscopy in proximal ureteral calculi: experience on 1238 cases**

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**Introduction and Objectives:** In the past 25 years, the treatment of proximal ureteral lithiasis evolved from ureterolithotomy to extracorporeal shockwave lithotripsy and/or ureteroscopy. Our objective was to analyse, in a significant series, the results of retrograde ureteroscopy in proximal ureteral lithiasis.

**Material and Methods:** Between June 1994 and February 2009, in our clinical department 5102 patients underwent retrograde ureteroscopy (5534 ureteroscopic procedures). Upper urinary tract lithiasis was the main indication, which was used in 4562 cases. The proximal ureteral calculi were treated on 1238 cases, 442 and 796 being larger and respectively smaller than 1 cm.

**Results:** The stone-free rate after one procedure was 86.5%. According to stone size, the success rates were 81.9% for calculi over 1 cm and 88.9% for stones smaller than 1 cm. Treatment failures were related to ascending migration of stone fragments (7.2%), impossible approach of the calculus (5.2%) and aborting the procedure due to complications (1.1%). The intraoperative

incidents occurred in 1.3% of the cases: fixed stone extractors (0.6%), equipment damages (0.4%) or JJ stent malpositioning (0.3%). The incidence of intraoperative complications was 3.4%: mucosal abrasion (1.4%), false passage (1%), ureteric perforation (0.5%), extra-ureteral stone migration (0.1%), bleeding (0.1%), ureteric avulsions (0.2%). Early complications were described in 10.2%. We also found late complications such as ureteral stenosis (2 cases) and persistent vesico-ureteral reflux (1 case).

**Conclusions:** According to our experience, ureteroscopy represents a valuable option in proximal ureteral lithiasis treatment with high stone-free rates and minimum morbidity.

#### C70

##### **Complications after 2000 percutaneous procedures**

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**Introduction and Objectives:** Percutaneous nephrolithotomy (PCNL) is nowadays a widely practiced procedure. Despite the good stone-free rates, it still has a specific morbidity. Our goal was to describe the complications of this method on a significant series of patients.

**Material and Methods:** Between January 2001 and January 2009, 2115 patients (age between 18 and 81 years old) underwent PCNL (2301 procedures). We used 24 F rigid nephroscopes (2204 procedures) and 15F flexible ones (126 procedures). The mean follow-up period was 67 months (range 3 to 132 months).

**Results:** Intraoperative incidents were encountered during 92 procedures (4%): losing the percutaneous tract (43 cases), poor visibility due to bleeding and imposing the termination of the procedure (35 cases) and descendant stone fragments' migration imposing antegrade ureteroscopic removal (14 cases). The overall complications' rate was 22% (506 cases): significant bleeding requiring blood transfusions (72 cases), nephrectomy (2 cases) or open surgical hemostasis (3 cases), sepsis (3 cases), fever (89 cases), pyelocaliceal perforations (35 cases), hemoperitoneum (1 case), persistent lumbar urinary fistulae requiring retrograde JJ ureteral stenting (299 cases) and extrarenal stone fragments migration (2 cases). However, the majority of these complications were minor. The mortality rate related to PCNL procedures was 0%.

**Conclusions:** According to our experience, PCNL is a safe and effective technique. Most of the intraoperative incidents or complications are minor and easy to solve. However, an adequate training is imperative in order to reduce the associated morbidity.

#### C71

##### **Bilateral single procedure percutaneous nephrolithotomy**

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**Introduction and Objectives:** Unlike SWL or ureteroscopy, the percutaneous renal approach is not limited by stone size. However, the inherent complications of this technique, some of which really significant, necessitate a rigorous selection of the cases.

**Material and Methods:** Since introducing the percutaneous approach in our department in 2001, more than 2000 patients benefited from this surgical technique. With the continuously expanding experience, we approached more and more complex cases, with good results and a decreasing rate of complications. Among the 2103 patients with lithiasis, 174 presented bilateral disease. 6 patients were operated by single session percutaneous