patients with prostate cancer had the pathological stage T2, only 1 patient had the pathological stage pT3a. In one case there was a prostate cancer with cT3b after the treatment (RT and OE) and we have not found any malignant cell in prostate. Mean age of patients with prostate cancer was 67 years against mean age of whole patient file.
Conclusions: Our results promote the published studies that affection of the prostate by transitional cell cancer and prostate cancer is relatively often finding in preparations after cystoprostatectomy. Prostate spearing radical cystectomy should be preventing particular examination to minimalize risk of holding the tumor in patient.

C100
Lateral decubitus position is less painful than lithotomy position for patients undergoing prostate biopsy

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Introduction and Objectives: The purpose of our study was to determine if patient's position during prostate biopsy can influence their perception of pain during procedure.
Material and Methods: Between February and November 2008 we performed transrectal ultrasound (TRUS) guided biopsies on 139 men. They were divided in 3 groups: group 1 was in lateral decubitus position (n = 41), group 2 was in lithotomy position with the insertion of intrarectal 2% lidocain gel (n = 50) and group 3 was in lithotomy position without gel (n = 48). All patients underwent biopsy for the first time. None of them were using analgesics at the time of procedure. Rectal abnormalities were excluded before insertion of ultrasound probe. 12-core samples were taken each time. Immediately after the procedure patients were asked to grade the pain they felt during the procedure with 10-point visual analogue scale (VAS).
Results: Kruskal – Wallis non-parametric test was used to compare three groups of sampled data. In group 1 median pain score was 2.6; in group 2 it was 4.95 and in group 3 it was 4.6. There is a significant lower perception of pain in the group in lateral decubitus position during biopsy (p = 0,00002).
Conclusions: Our study showed that lateral decubitus position could be less painful for patients than lithotomy position. There was no significant difference in pain perception between groups in lithotomy position regardless of applied lidocain gel.

C101
Detection of ETS translocations using Affymetrix exon 1.0 ST arrays

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Introduction and Objectives: Gene rearrangements can be an initial event in oncogenesis. Whereas prostate cancer (PrCa) specific TMPRSS2–ERG fusions are frequent genomic alterations, fewer TMPRSS2 fusions with other ETS transcription factors have been described. Cancer Outlier Profile Analysis (COPA) led to the identification of gene fusions in PrCa. Our recent study aims to use COPA analysis on the new Affymetrix exon 1.0 arrays to assess the prevalence of outliers in PrCa patients. We validated the technology using the ERG exon specific gene expression data.
Material and Methods: Based on the pathology findings of 70 radical prostatectomy specimens four groups of patients were identified: 1) low grade (LG-PrCa; n = 20), 2) high grade (HG-PrCa; n = 22) 3) castration resistant (CR-PrCa; n = 21) and 4) metastatic (Met-PrCa; n = 7). Following RNA isolation gene profiling was performed using a microarray technique (GeneChip, Affymetrix). We did bioinformatic analysis, including COPA on the standard gene set (23,000 genes).
Results: 250 outliers genes were identified on a microarray analysis. ETS transcription factors family genes: ERG, ETV1, ETV4 and ETV5 were selected for further experiments. ERG, ETV1, ETV4 and ETV5 were overexpressed in 39 (55%), 4 (5.7%), 2 (2.8%) and 2 (2.8%) of tumors, respectively. Further, in all tumors overexpressing ERG, TMPRSS2–ERG fusions were identified using an independent test. The overexpression of ETV1 and ETV5 was only observed in all cases of aggressive PrCa.
Conclusions: We confirmed in this COPA analysis of expression data from 70 prostate cancers the frequent overexpression of ETS oncogenes. Except from the common TMPRSS2–ERG fusions, we haven't been able so far to identify new 5′ fusions partners. Additionally, we were able to show that ETV1 and ETV5 were overexpressed in patients with aggressive PrCa. Therefore, exon 1.0 ST arrays can be used to lead the way in the discovery of gene fusions.

Poster session 7: Laparoscopy and Reconstructive surgery
Saturday, 24 October 2009, 09:20–11:30
Poster room 1

C102
Complete laparoscopic nephroureterectomy

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Introduction and Objectives: Urologists are still looking for the best method of accomplishing a nephroureterectomy (NUE). While a laparoscopic nephrectomy (LNE) as a part of NUE is yet broadly accepted, removing the ureter is still problematic – the approach (endoscopic, open, and laparoscopic) and consequence of steps. We present results of a recently described complete laparoscopic NUE (CLNU) with thermosealing system (Tsivian et al: Eur Urol, 2007, 52; 1015–9).
Material and Methods: We start CLNUE in the flank position with standard LNE through 4 (left side) or 5 ports (right side). The ureter is liberated with harmonic scalpel or thermosealing system (Ligasure Advance®) to the urinary bladder. The gonadal vein must to be cut off. Ureter is excised with bladder cuff with thermosealing system (Ligasure Atlas®) introduced through another suprapubic port 10 mm. Specimen is removed in bag through muscle splitting incision of the lower abdomen. A permanent bladder catheter is removed on the 5th postoperative day. From 4/2008 to 6/2009, 19 patients underwent NUE. Three LNUE with an open ureterectomy for an advanced tumour of the distal ureter, one open NUE with a lymphadenectomy for an advanced tumour of pelvis. Fifteen underwent CLNU. They are evaluated in details.
Results: Eight men and seven women, the mean age 68±8 (57–80) years. Five times on the left side, 10× on the right side. Tumour was in the renal pelvis 8×, in ureter 4× (2× in the distal ureter). The mean time of operation was 126±21 (86–160) min. In three cases, CLNUE was preceded 3× with cystoscopy (1× with transurethral resection of urinary bladder tumour) and 3× with diagnostic ureteroscopy, the time of the endoscopies wasn't included to the time of CLNUE. In one woman, CLNUE was performed ipsilateral to a transplanted kidney to the iliac fossa. The mean blood loss was 62± 57 (0–200) ml. The mean weight of specimen was 478±211 (210–1067) g. The histology