

was 12× urothelial cancer (1 pT3, 2 pT2, 5 pT1, 4 pTa), 1× clear renal cell carcinoma pT3aG2, 1× oncocytoma and 1× xantogranulomatous pyelonephritis. Complications were rare, only urinary tract infection with *B. coli* on 6th postoperative day. Fourteen patients were discharged from hospital on 7±2 (5–11) day, patient with transplanted kidney was transferred on 3rd postoperative day to department of nephrology. The mean follow-up is 8 (1–14) months; patient with transplanted kidney underwent TUR for recurrent non-muscle invasive bladder tumour.

Conclusions: CLNUE is minimally invasive, fast and safe method without need to change patient's position. It is feasible even ipsilateral to a transplanted kidney. Open approach is reserved for advanced tumours only. We recommend starting NUE always with LNE. Liberation of ureter in pelvis is technically challenging, in case of any problems in pelvis, open ureterectomy can be performed. Long term oncological results are unknown. The work was supported by Czech government research project MSM 0021620819.

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Strictures of urethrovesical anastomosis after laparoscopic radical prostatectomy: Risk factors and treatment options

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Introduction and Objectives: Strictures on vesicourethral anastomosis (VUA) after laparoscopic radical prostatectomies (LRP) are relatively common complication. Beside prolonged extravasation on anastomosis, operations on prostate or bladder neck, which were done before radical prostatectomy, as risk factors for strictures on VUA, we think that meticulous preparation on bladder neck and apex of prostate as much as technique of anastomotic suturing, are major factors for prevention of strictures on anastomosis.

Material and Methods: 733 patients with prostate carcinoma were operated between Years 2004 and 2009. Follow up was at 1, 3, 6, 12, 18 and 24 month. Strictures were diagnosed urethroscopically. When the stricture was diagnosed, it was resolved with incision, transurethral resection (TUR) or with open reconstructions of anastomosis. Method selection depended of length and degree of stricture.

Results: After median time of 5.8 months, we diagnosed stricture on VUA in 18 patients (2.2%). We founded that prolonged extravasation and operative technique of preparation of bladder neck, apex and construction of VUA, are major factors for prevention of stricture. Incision on anastomosis was performed in 15 patient, in 2 patients we did TUR and in one patient we had to do done open reconstruction.

Conclusions: Preparation of bladder neck and apex, as much as construction of anastomosis are very important risk factors for preventions of stricture on VUA. Good operative technique and maintaining maximal concentration during the whole procedure is crucial.

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Laparoscopic nephrectomy for advanced renal tumours (cT2 >8 cm, cT3a–b, cN+)

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Introduction and Objectives: Laparoscopic radical nephrectomy (LRN) is considered a standard of care in the treatment of

T1–2 (≤ 8 cm) renal tumours. The objective of this paper is to summarize our results and our own experience in the treatment of advanced renal tumours (cT2 >8 cm, cT3a–b, cN+).

Material and Methods: From January 2003 to June 2009, we have accomplished 281 LRN at our institution. Transperitoneal approach was preferred in 259 (92%) patients. We preoperatively indicated CT or MR angiography of kidneys. Tumor thrombus was present in renal vein not extending into IVC. In our cohort, we identified patients with cT1–2 (≤8 cm) tumours – group 1 – and statistically compared their perioperative data with clinically advanced renal tumours (14× cT2 >8 cm, 51× cT3a, 5× cT3b, 1× cT3acN2) – group 2.

Results: There were 195 (73.7%) patients in group 1 and 70 (26.3%) patients in group 2. We found statistically significant differences (p-value <0.05) between these two groups in terms of tumour size (51.6±13.0 mm in group 1 vs. 70.0±19.4 mm in group 2) and weight of specimen (550.8±199.1 g in group 1 vs. 691.6±233.4 g in group 2). Remaining perioperative data (group 1 vs. group 2) were statistically comparable (mean age was 61.9±11.7 yrs vs. 63.5±10.0 yrs, operating time was 128.9±45.9 min vs. 118.8±31.1 min, blood loss was 82.8±128.0 ml vs. 108.9±141.5 ml, hospitalization time was 6.4±2.2 vs. 5.3±1.3 days, complication rate was 6.2% vs. 8.6% and conversion rate was 5.8% vs. 5.4%). Mean follow-up was 34.2±20.1 months in group 1 vs. 25.8±17.8 months in group 2.

Conclusions: Minimally invasive surgery in the treatment of advanced renal tumours (cT2 >8 cm, cT3a–b, cN+) is feasible in selected patients and demands experienced laparoscopic surgeon. Surgical outcomes are then comparable with T1–2 (≤8 cm) group. These procedures should be centralized and performed in high volume centres.

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Extraperitoneal laparoscopic radical prostatectomy: Evaluation of learning curve

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Introduction and Objectives: Extraperitoneal laparoscopic radical prostatectomy (ELRP) is a technically exacting operative procedure. We demonstrate our center's learning curve.

Material and Methods: Between April 2005 and May 2009, 554 consecutive men with a mean age of 64.1 (range 47–72), a mean pre-operative PSA of 5.9 ng/ml and clinically localized prostate cancer underwent ELRP by six urologists at General Hospital Slovenj Gradec. Urologist I and II are senior surgeons that have extensive experience from transperitoneal laparoscopic radical prostatectomy and other laparoscopic procedures, urologist III has medium laparoscopic experience and other three urologists (IV–VI) have a little experience in laparoscopy. Operative time, estimated blood-loss and positive surgical margin rate were noted. All urologists assisted more than 100 transperitoneal laparoscopic radical prostatectomies before starting with ELRP. In order to our study the patients were divided into four subgroups consisting of the first 50 patients operated, the next 100, 150 and other 254 patients.

Results: In 5 patients the conversion was needed because of major bleeding. 11 complications required reoperation: 3 recto-vesical fistula, 1 rectal injury, 2 major bleeding and 5 anastomosis failure. There was no per-operative or post-operative mortality. Pathological stage was pT2 in 69.2% and pT3 in 30.8% tumors. Urologist I performed 178 operative procedures, urologist II 243, urologist III 54, urologist IV 42, urologist V 28 and urologist VI performed 9 procedures. Results of operative time, estimated blood-loss and positive surgical margin rate for all urologists are shown in the table.