

Message from the President

Welcome to the 2009 annual meeting of the Wisconsin Urological Society. We have an exciting and informative agenda planned, with outstanding speakers and topics. Our guest speakers this year include Dr. Michael Mitchell, a nationally known pediatric urologist from Milwaukee, and Dr. Linda Brubaker, an expert in urogynecology from Loyola University Chicago. Their presentations and following panel discussions should be of great interest to all of our attendees. We also have a wide range of clinical and basic science research presentations. In the afternoon, Dr. Bruce Neal will discuss practice management and the current socioeconomic climate. We hope that our meeting will prove to be a valuable educational experience for all of our attendees.

I would like to take this opportunity to say that it was an honor and a pleasure to serve as president this year. I owe thanks to the Board of Directors, Dr. Doug Dewire for his tireless efforts as secretary, and W.J. Weiser & Associates. Thank you all, as well, and enjoy the meeting!

Thomas A. Londergan, MD
WUS President, 2008 – 2009

About the Program

This activity is designed for the practicing urologist, residents in training and para-professionals in the urology field.

Program Needs

Urologists attending this meeting need to be aware of the latest advancements in surgical and non-surgical treatments for incontinence and voiding dysfunction. A review of the evaluation and treatment of pediatric urology disorders will also be of benefit to our members. There will also be a timely socio-economic update from our Wisconsin State Society Representative.

Educational Objectives

At the conclusion of this meeting, the attendee will be able to:

Pediatric Urology

- Describe and report the management of common pediatric urological problems, including infection, enuresis, hypospadias, and neurogenic bladder
- Identify state-of-the-art surgical techniques

Incontinence and Voiding Dysfunction

- Identify surgical techniques for incontinence and pelvic floor dysfunction, such as slings and vaginal vault prolapse repair
- Recognize non-surgical therapies for incontinence and pelvic floor dysfunction, such as pelvic floor physical therapy and biofeedback, medication, and external and implantable nerve stimulation

Practice of Urology

- Review market and political issues affecting urology practices in Wisconsin; topics will include the Patient's Compensation Fund lawsuit brought by the State Medical Society and how the 2008 elections will change the practice of medicine going forward

Wisconsin Urological Society Residents Program

The Wisconsin Urological Society recognizes the need for urology residents to network with, and be mentored by, experienced urologists in the field. To enhance their training, WUS offers a resident program to all urologists currently enrolled in a Wisconsin Teaching Institutions urology residents program. Our yearly resident essay competition will take place on Saturday, April 4, 2009 during the Society's annual meeting. All urology residents in the state of Wisconsin are encouraged to submit abstracts for presentation. Topics may be clinical or basic science and can cover any area of urology. All accepted abstracts are presented to the Society during the morning session. Awards will be given for first, second, and third place.

This year's WUS meeting will be held April 3 – 4, 2009 at the Pfister Hotel in Milwaukee, Wisconsin. All resident presenters will receive complimentary meeting registration, one night's hotel accommodations, and two tickets to the Friday night banquet from the Society.

This meeting is a great opportunity to share residency training and research ideas, as well as network with urologists in the state.

Accreditation

Continuing Medical Education

Accreditation Statement

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the University of Oklahoma College of Medicine and the Wisconsin Urological Society. The University of Oklahoma College of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

The University of Oklahoma College of Medicine designates this educational activity for a maximum of **6.25 AMA PRA Category 1 Credits™**. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Conflict Resolution Statement

The University of Oklahoma College of Medicine, Office of Continuing Medical Education has reviewed this activity's speaker and planner disclosures and resolved all identified conflicts of interest, if applicable.

Special Assistance

We encourage participation by all individuals. If you have a disability, advance notification of any special needs will help us better serve you. Call (847) 517-7225 if you require special assistance to fully participate in the meeting.

Program Schedule

Wisconsin Urological Society Annual Meeting April 3 – 4, 2009 The Pfister Hotel Milwaukee, Wisconsin

**All sessions located in Grand Center, unless otherwise noted.*

FRIDAY, APRIL 3, 2009

6:30 p.m. – 7:30 p.m.

Cocktail Reception

Location: Mezzanine

7:30 p.m.

Banquet

Location: The Rouge (Lobby Level)

SATURDAY, APRIL 4, 2009

6:30 a.m. – 4:15 p.m.

Registration

7:00 a.m. – 8:00 a.m.

Continental Breakfast with Exhibitors

Location: Imperial Ballroom

8:00 a.m. – 8:05 a.m.

Welcome

Thomas Londergan, MD

WUS President

8:05 a.m. – 9:00 a.m.

Pediatric Urology

“Reflux, What To Do Now!”

Michael Mitchell, MD

Children’s Hospital of Wisconsin

Milwaukee, WI

9:00 a.m. – 9:15 a.m.

Pediatric Urology Panel Discussion

Michael Mitchell, MD

Panelists: Charles T. Durkee, MD

John Kryger, MD

SESSION 1: PEDIATRIC UROLOGY

Moderator: Hrair G. Mesrobian, MD, Milwaukee

9:15 a.m. – 9:21 a.m.

ABSTRACT #1

Use of Ureter in Lower Urinary Tract Reconstruction in Children

Travis W. Groth, MD, Hrair G. Mesrobian, MD, Charles T. Durkee, MD, Michael E. Mitchell, MD, Anthony H. Balcom, MD

Presenter: Travis W. Groth, MD, Milwaukee

9:21 a.m. – 9:27 a.m.

ABSTRACT #2

Current Status of Vesico-Amniotic Shunting in Utero

Travis W. Groth, MD, Anthony H. Balcom, MD, Charles T. Durkee, MD, Hrair G. Mesrobian, MD, Michael E. Mitchell, MD

Presenter: Travis W. Groth, MD; Milwaukee

9:27 a.m. – 9:33 a.m.

ABSTRACT #3

Immature Testicular Teratoma in Twin Boys

John Kryger, MD, Sara Best, MD, Bruce Slaughenhoupt, MD

Presenter: John Kryger, MD, Madison

9:33 a.m. – 9:39 a.m.

ABSTRACT #4

Stone Disease in Children Less than Five Years of Age: A Ten-Year Experience

Amy Guise, MD, Charles T. Durkee, MD

Presenter: Amy Guise, MD, Milwaukee

9:39 a.m. – 9:45 a.m.

Q & A

SESSION 2: PROSTATE CANCER

Moderator: Peter Langenstroer, MD, Milwaukee

9:45 a.m. – 9:53 a.m.

ABSTRACT #5

Comparison of RRP Results in Patients with Prior Laparoscopic Herniorrhaphy Using Non-Absorbable Mesh (LMH) vs. a Control Without Prior LMH Repairs

Donald Neff, MD, William See, MD

Presenter: Donald Neff, MD, Milwaukee

9:53 a.m. – 10:01 a.m.

ABSTRACT #6

Impact of Immediate Repeat TRUS Biopsy in Patients Considering Surveillance for Prostate Cancer

Andre King, MD, Timo Laurila, MD,
William Huang, MD, David Jarrard, MD
Presenter: Andre King, MD, Madison

10:01 a.m. – 10:09 a.m.

ABSTRACT #7

Port site Metastasis After Robotic Assisted Laparoscopic Radical Prostatectomy

Matthew Christian, MD, O. Ogunyemi, MD,
Andrew Graf, MD
Presenter: Matthew Christian, MD, Madison

10:09 a.m. – 10:15 a.m.

Q & A

10:15 a.m. – 10:45 a.m.

Break with Exhibitors

Location: Imperial Ballroom

SESSION 3: KIDNEY / BLADDER

Moderator: Jason Gee, MD, Madison

10:45 a.m. – 10:52 a.m.

ABSTRACT #8

Robotic Partial and Radical Nephrectomy: Initial Experience

Kenneth M. Jacobsohn, MD, Mark J. Waples, MD
Presenter: Kenneth M. Jacobsohn, MD, Milwaukee

10:52 a.m. – 10:59 a.m.

ABSTRACT #9

Percutaneous Renal Cryoablation

Daniel Flewelling, MD, W. Relling, MD, S. Tutton, MD, Aaron Sulman, MD, Frank Begun, MD, Peter Langenstroer, MD
Presenter: Daniel Flewelling, Milwaukee

10:59 a.m. – 11:06 a.m.

ABSTRACT #10

Resonance Metallic Ureteral Stents Do Not Successfully Treat Ureteroenteric Strictures in Patients with Ileal Conduits

Tullika Garg, MD, Michael Guralnick, MD, Peter Langenstroer, MD, William S. See, MD, R. Hieb, MD, W. Rilling, MD, R. Corey O'Connor, MD

Presenter: Tullika Garg, MD, Milwaukee

11:06 a.m. – 11:13 a.m.

ABSTRACT #11

Laser Ablation of the Defunctionalized Bladder as an Alternative to Cystectomy

Amy Guise, MD, Robert F. Donnell, MD

Presenter: Amy Guise, MD, Milwaukee

11:13 a.m. – 11:20 a.m.

ABSTRACT #12

High Molecular Group Box Protein 1 (HMGB1) Increases the Direct Cytotoxic Effect of BCG on Human Urothelial Carcinoma Cells

Nathan R. Rasmussen, MD, William S. See, MD

Presenter: Nathan R. Rasmussen, MD, Milwaukee

11:20 a.m. – 11:27 a.m.

ABSTRACT #13

Robotic Radical Cystectomy and Urinary Diversion

Kenneth M. Jacobsohn, MD, Brett A. Laven, MD

Presenter: Kenneth M. Jacobsohn, MD, Milwaukee

11:27 a.m. – 11:34 a.m.

ABSTRACT #14

Infraumbilical Midline and Pfannenstiel Incisions as Cosmetic Alternatives for Urinary Diversion Following Robotic Cystectomy

Jason Gee, MD, Sean Hedican, MD, Daniel Kaplon, MD, Reginald Bruskewitz, MD, Stephen Nakada, MD, David Jarrad, MD

Presenter: Jason Gee, MD, Madison

11:34 a.m. – 11:41 a.m.

Discussion

SESSION 4: INFERTILITY / SEXUAL MEDICINE 1

Moderator: Douglas M. Dewire, MD, Milwaukee

11:41 a.m. – 11:49 a.m.

ABSTRACT #15

Two Case Reports of Rare Genetic Anomalies Resulting in Male Infertility and Hypogonadism

Daniel Williams, MD, Kara Babaian, MD
Presenter: Kara Babaian, MD, Madison

11:49 a.m. – 11:57 a.m.

ABSTRACT #16

Patient Preference of Testosterone Gel (Androgel or Testim) Among Hypogonadal Men Beginning Testosterone Replacement Therapy

Daniel Williams, MD, David Paolone, MD, Christopher Manakas, MD, Edward Karpman, MD
Presenter: Christopher Manakas, MD, Madison

11:57 a.m. – 12:05 p.m.

ABSTRACT #17

The Use of Clomiphene Citrate in Non-Responders to Varicocelectomy

Jay Sandlow, MD, J. Tomasini, MD
Presenter: J. Tomasini, MD, Milwaukee

12:05 p.m. – 12:10 p.m.

Discussion

12:10 p.m. – 1:05 p.m.

Lunch with Exhibitors

Location: Imperial Ballroom

1:05 p.m. – 1:55 p.m.

Female Urology – Surgical and Non-Surgical Treatment of Incontinence / Prolapse

Linda Brubaker, MD
Loyola University
Maywood, IL

1:55 p.m. – 2:15 p.m.

Panel Discussion

Linda Brubaker, MD
Panelists: Margaret Kressin, MD
Sarah McAchran, MD

SESSION 5 – INFERTILITY 2

Moderator: Daniel Williams, MD, Madison

2:15 p.m. – 2:23 p.m.

ABSTRACT #18

Information About Female-Factor Infertility on Websites of Male Infertility Specialists in the Midwest

Crystal Dover, MD, Daniel Williams, MD

Presenter: Crystal Dover, MD, Madison

2:23 p.m. – 2:31 p.m.

ABSTRACT #19

Varicocelectomy Results in Significant Improvement of Total Regardless of Preoperative Seminal Parameters

Anand Shridharani, MD, Jay Sandlow, MD

Presenter: Anad Shrinidharani, MD, Milwaukee

2:31 p.m. – 2:39 p.m.

ABSTRACT #20

Case of Performing Electroejaculation in a Non-Spinal Cord Patient

Margarita Kressin, MD, C. Lythgoe, MD

Presenter: Margarita Kressin, MD, Milwaukee

2:39 p.m. – 2:45 p.m.

Discussion

2:45 p.m. – 3:05 p.m.

“Practical Matters for the Practicing Urologist”

Practice Management, Socio-Economic Update, Advocacy

Bruce Neal, MD

Wisconsin Health Policy Representative

SESSION 6: VOIDING DYSFUNCTION

Moderator: R. Corey O'Connor, MD Milwaukee

3:05 p.m. – 3:13 p.m.

ABSTRACT #21

**Voiding Dysfunction in Patients with
Dysautonomia**

Anand Shridharani, MD, Michael Guralnick, MD,
A. Barboi, MD, S. Jaradeh, MD, T. Prieto, MD, M.
Yellick, MD, R. Corey O'Connor, MD
Presenter: Anad Shrindharani, MD, Milwaukee

3:13 p.m. – 3:21 p.m.

ABSTRACT #22

**Success of Sacral Neuromodulation Stratified
by Age**

Paul Tonkin, MD, Michael Guralnick, MD, R.
Corey O'Connor, MD
Presenter: Paul Tonkin, MD, Milwaukee

3:21 p.m. – 3:29 p.m.

ABSTRACT #23

**Valsalva Voiders are at Increased Risk of
Urinary Retention after Urethral Sling
Placement for Stress Urinary Incontinence**

Khanh Pham, MD, N. Topp, MD, Michael
Guralnick, MD, S. Koduri, MD, J. Newcomer,
MD, R. Corey O'Connor
Presenter: Khanh Pham, MD, Milwaukee

3:29 p.m. – 3:37 p.m.

ABSTRACT #24

**The Success of Pelvic Floor Physical Therapy
Treatment on Male LUTS and Pelvic Floor
Dysfunction**

Margarita Kressin, MD, Elizabeth Malak, MD
Presenter: Margarita Kressin, MD, Milwaukee

3:37 p.m. – 3:45 p.m.

Discussion

3:45 p.m. – 4:15 p.m.

Annual Business Meeting

4:15 p.m.

Adjourn

Abstracts

ABSTRACT #1

Use of Ureter in Lower Urinary Tract Reconstruction in Children

Travis W. Groth, MD, Hrair G. Mesrobian, MD, Charles T. Durkee, MD, Michael E. Mitchell, MD, Anthony H. Balcom, MD; Medical College of Wisconsin, Children's Hospital of Wisconsin

Purpose: The Mitrofanoff principle, first described in 1980, has been used to construct a catheterizable continent channel for intermittent catheterization of the bladder. Since Mitrofanoff's original description of construction of a catheterizable channel, there have been multiple variations described for its creation, including, the appendix, ileum (Yang-Monti and Casale), bladder tube, fallopian tube, vas and ureter. The appendix has been preferentially used when available. Not infrequently, the appendix is not present or amenable for use. We present our experience using the ureter for lower urinary tract construction, specifically emphasizing on the ureteral Mitrofanoff channel.

Materials and Methods: We retrospectively reviewed our experience with ureteral Mitrofanoff's. A total of sixteen patients were identified from 1991-2008 (10 males and 5 females). The age ranged from 1-8 years at time of initial surgery with a mean age of 3.6 years. There were various abnormalities of the lower urinary tract. These diagnoses included: prune belly syndrome (7), myelomeningocele (2), urethral atresia (2), bilateral ectopic ureter (1), bladder exstrophy (1), cloacal exstrophy (1), sacral agenesis (1), and bladder agenesis (1). Indications for use of the ureter included preferential use of the appendix for continent cecostomy, concomitant removal of a non-functioning kidney, severe ureteral dilation and unsuitable appendix.

Results: Follow-up ranged from 5 months to 17 years. Almost universally, patients and families were able to catheterize their ureteral channels without difficulty or discomfort. Complications included stomal stenosis in 3, ureteral stenosis in 2, difficulty catheterizing in 1, and incontinence in 1 patient.

Conclusion: The Mitrofanoff principle is a reliable method for construction of continent catheterizable channels. Appendix or tubularized ileum (Casale or Yang-Monti) will typically continue to be a first line option in the construction of continent catheterizable channel. In select situations, however, the ureteral Mitrofanoff is a reliable catheterizable channel.

ABSTRACT #2

Current Status of Vesico-Amniotic Shunting in Utero

Travis W. Groth, MD, Anthony H. Balcom, MD, Charles T. Durkee, MD, Hrair G. Mesrobian, MD, Michael E. Mitchell, MD

Presenter: Travis W. Groth, MD; Milwaukee; Children's Hospital of Wisconsin, Medical College of Wisconsin

Purpose: Indications for placement of Vesico-Amniotic (VA) shunt In Utero have evolved over the past 2 decades. Bladder outlet obstruction with bilateral hydronephrosis and progressive oligohydramnios was, and is, the classic indication for VA shunting.

Materials and Methods: We will present a review and discussion of our experience caring for Fetuses and Newborns who underwent In Utero VA shunt placement. Frequent diagnoses included Posterior Urethral Valves, Obstructive Ureterocele, Prune Belly, Obstructed Solitary Kidney in Utero, and Urethral Atresia.

Results/Conclusions: Our clinical experience has allowed refinement of timing of VA shunting, tending towards earlier VA shunt placement. Accurate recognition of normal pulmonary development in Utero, better Ultrasound technology, better identification of Prune Belly Sequence versus Prune Belly Syndrome In Utero, and advances in Neonatal care of the pulmonary and Renal compromised premature infant have led to refinements of the indications for and timing of placement of Vesico-Amniotic shunt placement. This information allows us to better inform patient's families of the risks and benefits of Vesico-Amniotic shunt placement In Utero.

ABSTRACT #3

Immature Testicular Teratoma in Twin Boys

John Kryger, MD, Sara Best, MD, Bruce Slauchhupt, MD

Introduction: We present a case of identical twin 4-month-old boys both with testicular teratomas.

Case Presentation: Healthy identical twin 4-month-old boys presented to their pediatrician with solid left scrotal masses. Scrotal ultrasounds revealed heterogeneous left testicular masses consistent with tumor in both boys and in one child, a 3mm right testicular cyst. Tumor markers consisting of B-HCG and AFP were drawn prior to orchiectomy. Both boys' B-HCG levels were normal. The AFP levels were 1131 ng/ml and 1223 ng/ml, both felt to be appropriate for their age. Examination of both left testes upon their delivery into the inguinal wounds showed no demarcation between the masses and any "normal-appearing" testis that would allow partial orchiectomy, so radical orchiectomy

was completed. Pathological analysis revealed 2.5cm immature teratomas in both patients. CT scans and chest radiographs of both boys were normal. Genetic analysis of the tumor revealed that the boys have Klinefelter's syndrome. At last follow up, seven months after surgery, both boys have recovered well. The testicular cyst seen in the one boy is stable in size and continues to be followed.

Discussion: Pediatric testicular teratomas occur in 0.5 to 2/100,000 boys annually and the mean age of presentation is thirteen months of age. The majority of these tend to be mature and benign. Less commonly, boys may have immature tumors, though these also tend to have a benign course. Patients with Klinefelter's syndrome are at higher risk for several malignancies, including testicular cancer, though these tend to be postpubertal. For this reason, some have advocated for screening scrotal ultrasounds in patients with this syndrome.

ABSTRACT #4

Stone Disease in Children Less than Five Years of Age: A Ten-Year Experience

Amy Guise, MD, Charles T. Durkee, MD

Urinary calculi in children under 5 years of age is uncommon. A retrospective chart review from 1997 until the present was performed on all patients at our institution under the age of 5 years with urinary tract calculi. Twenty-six patients were identified. Their presenting symptom, co-morbid conditions, family history, imaging, treatment modality utilized, stone composition, and complications were reviewed. We found few children to have predisposing co-morbidities. We were able to safely and successfully treat the majority of patients with a single intervention.

ABSTRACT #5

Comparison of RRP Results in Patients with Prior Laparoscopic Herniorrhaphy Using Non-Absorbable Mesh (LMH) vs. a Control Without Prior LMH Repairs

Donald Neff, MD, William See, MD; Milwaukee, WI

Introduction and Objective: Laparoscopic herniorrhaphy employing non-absorbable mesh (LMH) was a frequently performed procedure during the 1990s and early 2000s. Multiple case reports in the urologic literature have identified LMH as a complicating factor in patients undergoing open radical retropubic prostatectomy (RRP) for prostate cancer. Reported outcomes range from "procedure abandonment" to "bladder debridement complicating the vesico-urethral anastomosis". The purpose of this study was to review our experience and outcomes in patients with a prior LMH undergoing open RRP.

Methods: A retrospective review of all open RRP performed by a single surgeon between 2003 and 2008 was used to identify patients with a history of a prior LMH. The outcomes of these patients were compared to a contemporary cohort of patients undergoing RRP by the same surgeon. Statistical analysis employing the Student T test, or Fischer Exact test was used to compare the groups for baseline comparability (Age, preoperative PSA, prostate size, Preoperative Gleason Score, Body Mass Index), and for select outcome measures (Length of Hospitalization, Length of Surgery, Estimated Blood Loss, 24 hour Pain index, and complication rate).

Results: Eighteen patients with a prior LMH underwent RRP. Five of the 18 had bilateral LMH with unilateral LMH in the remainder. Outcomes in this group were compared to 38 patients without prior LMH. RRP was successfully performed in all 18 LMH patients. One of 18 patients had a post-operative complication (persistent JP drainage). The table below lists the averages for each of the studied groups/variables together with the results of the statistical comparisons.

Outcome Comparison										
	Age	PSA	Gleason Score	Prostate Size (gm)	BMI	Length of Surgery (min)	EBL (ml)	Pain Scale (x/10)	Length of Stay (hrs)	Complications
Normal Group (mean)	58	6.2	6.6	38.1	28.4	193	354	2.2	45	1/19
LMH group (mean)	60	7.0	6.7	41.8	28.2	204	463	2.6	49	0/38
p Value	0.28	0.53	0.77	0.40	0.86	0.07	0.07	0.44	0.27	0.30

Conclusions: In patients undergoing RRP a prior LMH is associated with modest increases in operative time, and EBL. While resulting in increased operative complexity, our results indicate that RRP can be successfully and safely performed in these patients.

ABSTRACT #6

Impact of Immediate Repeat TRUS Biopsy in Patients Considering Surveillance for Prostate Cancer

Andre King, MD, Timo Laurila, MD, William Huang, MD, David Jarrard, MD; University of Wisconsin, Department of Urology

Introduction: Active surveillance (AS) is an option for the management of low-volume, low-grade prostate cancer. To date, the impact of immediate TRUS rebiopsy on a select group of patients considering AS has been incompletely defined.

Methods: From a total of 397 men newly diagnosed with prostate cancer (2005-present), 35 met strict criteria for active surveillance (Gleason score of ≤ 6 (or focal Gleason 7 in older patients), PSA < 10 , ≤ 2 cores involved, $< 10\%$ individual core involvement and T1c). Of these, 17 candidates for intervention elected immediate 10-12 core rebiopsy emphasizing the previously affected lobe (3:2 ratio). Histopathologic outcomes and the impact on therapeutic choice were examined.

Results: Mean cohort age was 61.7y (range 56-72y), PSA 5.65 ng/ml, and PSA density 0.11 ng/ml/cc. On initial biopsy 15/17 men had Gleason scores of 6 and two older patients (> 70 y) had focal Gleason scores of 7. Mean core involvement was 1.1 and tumor encompassed 1.5% (range 1-5%) of total biopsy tissue. Average time to rebiopsy was 2.6 months. Notably, 10/17 (59%) demonstrated no evidence of cancer on immediate repeat biopsy. We found 5/7 with a positive repeat biopsy showed increased cancer extent (average 4.6%) with two patients found to have $> 10\%$ of a core involved on rebiopsy. No change in grade was noted in any rebiopsy specimen. Three men chose curative intervention based on increased cancer volume (2) and concern with cancer (1). Both individuals undergoing surgery had capsular confined, margin negative disease.

Conclusions: In a modern cohort of men qualifying for active surveillance, immediate repeat biopsy infrequently (12%) results in significant changes in histopathologic diagnosis and curative intervention. Given the prolonged natural history of lower grade prostate cancers, rebiopsy at one year appears to be an acceptable approach to management in this group.

ABSTRACT #7

Port site Metastasis After Robotic Assisted Laparoscopic Radical Prostatectomy

Matthew Christian, MD, O. Ogunyemi, MD, Andrew Graf, MD; Madison, WI

Robotic assisted laparoscopic radical prostatectomy (RALRP) has become a widely accepted method for the treatment of clinically localized prostate cancer. The use of laparoscopy to treat urologic cancers is not without its risks. Port site metastasis is a rare but significant cause of patient morbidity and mortality. Port site metastasis has been reported in urothelial cell carcinoma, renal cell carcinoma, and after pelvic lymph node biopsy of high grade prostate cancer. We present a case of port site metastasis from high grade prostate cancer after attempted RALRP. There have been 2 other case reports of port site metastasis after laparoscopic surgery for prostate cancer. To our knowledge, this is the first case report of a port site metastasis after attempted RALRP.

ABSTRACT #8

Robotic Partial and Radical Nephrectomy: Initial Experience

Kenneth M. Jacobsohn, MD, Mark J. Waples, MD; Milwaukee, WI

Purpose: Robotic assisted renal surgeries for renal malignancies are rapidly increasing in popularity. Here we describe our early experience with robotic partial and radical nephrectomy for enhancing renal masses.

Methods: In September 2008 one fellowship-trained robotic surgeon (KMJ) and one experienced open surgeon (MJW) began performing extirpative robotic renal surgery for enhancing renal masses using a 3 and 4 arm technique on the DaVinci S Intuitive Surgical System (Sunnyvale, CA).

Results: To date 9 patients have undergone robotic renal surgery for enhancing renal masses. Five partial and four radical nephrectomies have been performed. All cases have been completed successfully without intraoperative complication or conversion to open surgery. For robotic partial nephrectomy mean patient age was 63 (range 36-80) warm-ischemia time was 23.6 minutes (range 16-31), tumor size was 3.0 cm (1.7-4.5), estimated blood loss was 134 (20-400), length of stay was 3 days (2-6), and body mass index was 32.2 (19.1-46). All margins have been negative. For robotic radical nephrectomy mean age was 56.6 (43-70), EBL was 100 (50-150), length of stay was 3 days.

Conclusions: Robotic partial and radical nephrectomy can be performed safely in the community setting. Our perioperative outcomes compare favorably with published series.

ABSTRACT #9

Percutaneous Renal Cryoablation

Daniel Flewelling, MD, W. Relling, MD, S. Tutton, MD, Aaron Sulman, MD, Frank Begun, MD, Peter Langenstroer, MD; Milwaukee, WI

Introduction: Percutaneous renal cryoablation is a minimally invasive, nephron sparing surgical procedure with encouraging results for a select patient population.

Methods: Since January 2007 we selected 28 patients to undergo percutaneous renal cryoablation with appropriately positioned renal masses <3cm in size. Continued surveillance for recurrence is performed with CT scans approximately every 3 months to detect local and/or distant recurrence.

Results: To date, we have performed 28 procedures with minimal peri-operative morbidity. There have been no additional peri-operative interventions, re-admissions, or blood transfusions. Renal function was preserved in all cases. There has been no evidence of local and/or distant recurrence on follow up. Our results are similar to previous reports in the literature.

Conclusion: Percutaneous renal cryoablation appears to be a viable outpatient, nephron sparing procedure for the management of select, small renal masses. Further follow up is required.

ABSTRACT #10

Resonance Metallic Ureteral Stents Do Not Successfully Treat Ureteroenteric Strictures in Patients with Ileal Conduits

Tullika Garg, MD, Michael Guralnick, MD, Peter Langenstroer, MD, William S. See, MD, R. Hieb, MD, W. Rilling, MD, R. Corey O'Connor, MD; Medical College of Wisconsin, Milwaukee, WI

Objective: To report the outcomes of patients with ureteroenteric strictures following ileal conduit urinary diversion treated with Cook Resonance metallic stent placement.

Methods: Ten ureteroenteric anastomotic strictures in patients with ileal conduits treated with metallic ureteral stenting were retrospectively identified. Charts were examined for patient age, anastomosis type, stricture cause, stricture laterality, complications, and follow-up.

Results: Nine of 10 (90%) cases resulted in distal stent migration. Mean time to identification of stent migration was 21 days (range 3-60).

Conclusions: Placement of Resonance metallic stents in patients with ileal conduits is ineffective for management of ureteroenteric strictures due to the high rate of distal migration.

ABSTRACT #11

Laser Ablation of the Defunctionalized Bladder as an Alternative to Cystectomy

Amy Guise, MD, Robert F. Donnell, MD; Milwaukee, WI

Introduction: Pyocystis is a common problem in patients with defunctionalized bladders after urinary diversion. Traditional treatments range from antibiotic irrigation, to drainage, to subtotal cystectomy.

Methods: We have employed a novel endoscopic technique of ablation of the bladder mucosa using ND: Yag laser in this clinical setting. Denuding the urothelium eliminates mucous production and allows the detrusor to contract down and scar shut.

Results: We have a series of 7 patients from 1997 to 2008 who have successfully undergone ND: yag laser ablation for treatment of pyocystis. All operative times were less than 2 hours and blood loss was minimal. Mean hospital stay was less than 24 hours.

Conclusion: This new minimally invasive technique is an effective alternative to cystectomy for the problematic defunctionalized bladder.

ABSTRACT #12

High Molecular Group Box Protein 1 (HMGB1) Increases the Direct Cytotoxic Effect of BCG on Human Urothelial Carcinoma Cells

Nathan R. Rasmussen, MD, William S. See, MD; Milwaukee, WI

Introduction: Intravesical administration of the attenuated mycobacterium, Bacille Calmette Guerin (BCG), is the unparalleled treatment for patients with high risk, non-muscle invasive urothelial carcinoma of the bladder. The mechanism by which BCG triggers its antitumor effect is incompletely understood. BCG induces a p21 dependent necrosis pathway, resulting in a direct tumoricidal effect and release of HMGB1 into the extracellular environment. We hypothesize that cellular release of the powerful chemokine HMGB1, occurring as a consequence of necrotic cell death, is a requisite element for the recruitment and activation of the ensuing local cellular immune response and, ultimately, the antitumor response.

Methods: We have developed a cell line with inducible overexpression of HMGB1, which is retained intracellularly, and maintains their “necrotic” response to BCG. HMGB1 release will be limited to those cells undergoing necrosis in response to BCG. Inducible, rather than constitutive, expression was chosen to decrease the risk of “unrecognized” changes in tumor biology occurring as a consequence of constitutive overexpression of HMGB1.2 MB49 cells have been transfected with constructs encoding a homolog of HMBG1 that will include a histidine tag, and this construct will be inducible by tetracycline. The “parental” cell line (69) and the transfected cell line (69-12) will each have four treatment groups:

1. Vehicle_{BCG} + Vehicle_{Tetracycline}
2. Vehicle_{BCG} + Tetracycline (Induced)
3. BCG + Vehicle_{Tetracycline}
4. BCG + Tetracycline (Induced)

Results: In each of these, the necrotic response of the cells was quantitated using trypan-blue exclusion. There appears to be a significant increase in percentage of non-viable cells in the 69-12 treated with tetracycline alone compared to 69 cells treated with tetracycline alone. There appears to be no significant difference in the percentage of nonviable cells in the BCG-treated groups (both with and without tetracycline).

Conclusion: These results demonstrate that increasing HMGB1 expression alone results a similar degree of cell death compared to BCG treatment alone. This seems to suggest that HMGB1 may be required for BCG to exert its tumoricidal effect.

ABSTRACT #13

Robotic Radical Cystectomy and Urinary Diversion

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Purpose: To report our initial experience with robotic-assisted radical cystectomy (RARC) for urothelial carcinoma.

Methods: Two fellowship trained robotic surgeons performed robotic radical cystectomy with ileal conduit urinary diversion using the daVinci surgical system (Intuitive Surgical, Sunnyvale, CA).

Results: From September 2008 through December 2008 four male patients have undergone RARC. Mean age was 80.5 (range 77-83), operative time was 4.3 hours (4-5.3), EBL was 142 ml (100-200). Mean lymph node count in the 3 patients who underwent an extended lymphadenectomy was 19.6 (15-23). Path was T1G3 + CIS + Gleason 4+3=7 prostate cancer in 1, T3N0 in 1, T3N1 in 1, and T4a sarcomatoid urothelial carcinoma in 1. All margins were negative and there were no intraoperative complications. One patient had prior brachytherapy for prostate cancer and one patient had prior nephroureterectomy for upper tract urothelial carcinoma.

Conclusions: RARC can be safely performed in the community setting. Our early perioperative outcomes are similar to those in published series.

ABSTRACT #14

Infraumbilical Midline and Pfannenstiel Incisions as Cosmetic Alternatives for Urinary Diversion Following Robotic Cystectomy

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Introduction: Robotic-assisted laparoscopic radical cystectomy (RALRC) offers reduced blood loss (EBL) and postoperative pain although the approach to urinary diversion may vary. We present the feasibility and outcomes of patients undergoing robotic cystectomy with the Pfannenstiel and lower midline incisions in creating ileal conduit and neobladder urinary diversions.

Methods: Eight patients from June to December 2008 with clinically organ-confined bladder cancer underwent RALRC with either a lower midline (10 cm) incision for an extracorporeal ileal neobladder or Pfannenstiel incision for an ileal conduit. Objective parameters include surgical margins, operative time, EBL, postoperative pain management, anastomotic urinary extravasation, length of hospitalization, continence, and complications.

Results: The infraumbilical lower midline and Pfannenstiel incisions afforded excellent exposure creation of an ileal neobladder or conduit. Average EBL (430cc) was substantially reduced although neither operative time nor average length of hospital stay (8.4 days) was improved as compared to open radical cystectomy. Postoperative patient controlled analgesia required a minimum cumulative dose of 18mg dilaudid. No anastomotic leakage occurred

postoperatively and 4/4 initial patients have recovered daytime continence without pads within 2 months. Surgical margins were negative for all patients. **Conclusions:** Robotic cystectomy accompanied by a small infraumbilical midline or Pfannenstiel incision is safe and effective for creation of the ileal neobladder and ileal conduit respectively.

ABSTRACT #15

Two Case Reports of Rare Genetic Anomalies Resulting in Male Infertility and Hypogonadism

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Introduction: We report two cases of rare genetic anomalies that resulted in male infertility and hypogonadism.

Case 1: In the first case, this 51 year-old man presented with a low-impact wrist fracture. A bone mineral density test showed osteoporosis. Further evaluation of his osteoporosis led to the diagnosis of severe hypogonadism with a total testosterone of 122 ng/mL. All other hormone levels were normal except for an elevated FSH of 36.0 mIU/mL. A pituitary MRI was normal. He was of very short stature at 4'8" and weighed 122 pounds. He had no other medical history. He had never initiated a pregnancy. A karyotype revealed mosaic 46,XY/45,X with a ring Y chromosome, specifically 46,X,r(Y)(p11.3q11.23)/45,X. The breaks causing the ring formation occurred at band Yp11.3 on the short arm, and band Yq11.23 on the long arm. This resulted in deletion of the terminal portion of the short arm and deletion of the long arm from q11.23 to qter.

Case 2: In the second case, this 41 year-old man presented for an infertility evaluation and was found to have normal volume, fructose positive, and azoospermia. He had a history of a right undescended testicle but never underwent orchidopexy. He was morbidly obese with a BMI of 53.1. His FSH was elevated at 15.1 mIU/mL, and he was found to be severely hypogonadal with a total testosterone of 88 ng/dL. All other hormone levels, as well as a pituitary MRI, were normal. Y-chromosome microdeletion assay was normal, however, his karyotype revealed 47,XY,+mar. This was a male karyotype with a modal number of 47 chromosomes and a supernumerary, structurally abnormal marker chromosome (mar). The marker was bisatellited, derived from the acrocentric chromosomes of short arms, which mostly contained repetitive DNA sequences. FISH analysis showed positive hybridization for the 15p11.2 region probe in the short arm of chromosome 15. No signal for the Prader-Willi/Angelman Syndrome was observed. The marker was iso-dicentric, derived of two copies of the chromosome 15 centromeric region and the p arm. Our patient presented with infertility. However, most reported cases of chromosome 15 derived small supernumerary isodicentric chromosomes that did not contain the Prader-Willi/Angelman Syndrome critical region, did not show association with abnormal phenotypes.

Results: Abnormalities in chromosome number and structure affect the separation of chromosomes during meiosis, which disrupts spermatogenesis and can lead to infertility. In addition, there have been two reported cases of transmission of ring Y chromosomes to offspring by intracytoplasmic sperm injection.

Conclusion: These two cases emphasize the need for genetic evaluation in cases of severe hypogonadism and nonobstructive azoospermia. Such testing can help patients understand the underlying cause of their condition and can help provide appropriate genetic counseling prior to the use of advanced reproductive techniques.

ABSTRACT #16

Patient Preference of Testosterone Gel (AndroGel or Testim) Among Hypogonadal Men Beginning Testosterone Replacement Therapy

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Introduction and Objective: AndroGel® and Testim® are the only two FDA approved topical gels for testosterone replacement therapy. Both of these daily preparations have been shown to be safe and effective methods of raising serum testosterone levels in hypogonadal men. Each medication is compounded uniquely and has different characteristics including pharmacokinetics, texture and fragrance. The primary objective of this study was to determine whether or not patients had a preference of testosterone gel based on fragrance.

Methods: This study group included 100 consecutive patients with a new diagnosis of hypogonadism who elected to undergo testosterone replacement therapy with a topical gel. After appropriate counseling about the risks and benefits of testosterone replacement therapy, each patient was shown placebo samples of AndroGel® and Testim®. Patients applied one placebo onto the back of one hand, and the other to the back of their other hand. They were asked to smell both placebos and decide which gel they wished to try based on the fragrance of the gel. If the patient had no preference, the choice of gel to prescribe was determined by the individual prescription plan coverage.

Results: 26 patients preferred the fragrance of AndroGel®, 34 preferred the fragrance of Testim®, and 40 patients had no preference for AndroGel® or Testim® based on the fragrance of the gel.

Conclusions: In this study, hypogonadal men beginning testosterone replacement therapy had no specific preference of testosterone gel based on fragrance.

ABSTRACT #17

The Use of Clomiphene Citrate in Non-Responders to Varicocelectomy

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Introduction and Objective: Varicocele is the most common etiology seen in male factor infertility. However, approximately 1/3 of men who undergo varicocelectomy (Vx) do not have a significant response in seminal parameter improvement. Clomiphene citrate (CC) has been utilized as empiric therapy in male factor infertility for many years. It has been shown that men with varicoceles have altered testosterone (T) production and CC has been shown to improve testicular function by raising T levels. Therefore, we hypothesized that men who failed to respond to Vx may respond to CC.

Methods: After IRB approval, a retrospective chart review was done for men who underwent microscopic subinguinal Vx performed by a single surgeon (JS). In patients who did not have significant improvement of their seminal parameters at either 3 or 6 month follow up, as defined by >50% increase in total motile sperm/ejaculate (TME), CC 25 mg 3 times/week was offered. The timing was based on previous data that demonstrated that over 80% of patients who improve after Vx do so within the first 3 months.

Results: A total of 22 pts began this medication, with follow up SA data on 16 pts. Seven pts (44%) had a significant improvement in their TME. Hormonal data both pre and post CC demonstrated that 3/7 (43%) of those who improved were hypogonadal (serum total T <300 ng/dl) prior to CC. This is in contrast to only 1/8 (13%) who did not improve starting with a low serum total T. All men became eugonadal after CC, without any having suprphysiologic T levels.

Conclusions: Most men who undergo Vx have significant improvement in their seminal parameters. However, in those who do not improve, the addition of CC may offer some benefit to almost half of these pts. It appears that men who are relatively hypogonadal may be more likely to improve than those who are eugonadal.

ABSTRACT #18

Information About Female-Factor Infertility on Websites of Male Infertility Specialists in the Midwest

Crystal Dover, MD, Daniel Williams, MD

Presenter: Crystal Dover, MD, Madison, WI

Introduction and Objective: Every year, millions of couples are faced with infertility and seek work up and treatments for their inability to conceive. As the internet continues to grow as a source of readily accessible medical information, there is an increasing need to evaluate the information available to patients as it may influence their choices to seek medical attention or adhere to treatment plans. A study from 2005 showed that 62% of women and 41% of men based their decision to seek medical treatment for infertility on information obtained

from the internet. We previously reported that information about male factor infertility is lacking on fertility clinic websites in the United States. The objective of this study was to evaluate the websites of male infertility specialists in the Midwest for content and information pertaining to female factor infertility.

Methods: We queried the Society for the Study of Male Reproduction (SSMR) and Society for Male Reproduction and Urology (SMRU) websites to obtain names of physicians listed as members of these societies. We limited our search to physicians located in the Midwestern states (Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, and Wisconsin). If a physician did not have a website (or websites) listed on the SSMR or SMRU pages, we performed a Google search using the physician's name and the keywords "infertility" and "urology". We categorized the websites as academic or private, and evaluated them for content, presence or absence of information on female infertility, links to reproductive endocrinology or assisted reproductive facilities, mention of vasectomy reversal, and biased language that could dissuade a couple from seeking a male or female factor evaluation.

Results: We identified 57 physicians who were members of the SSMR, SMRU, or both. Seventy-four percent of them had websites. Of all the physicians, 65% had private or academic websites that were not paid-marketing websites. Fifty-eight percent of the physicians reported to be fellowship-trained, while 42% listed no fellowship among their training. Forty percent of the physicians held academic positions or affiliations, 55% were private, and 5% were unknown. 69% of the websites mentioned vasectomy reversal. Only 31% of websites mentioned female fertility with an average of 1 mouse click required to reach the information. Seven of the sites had links to reproductive endocrinology specialists.

Conclusions: Infertility can be an emotional, stressful, and private matter. For this reason, many couples seek support, advice, and health information on the internet in an effort to empower themselves with knowledge. Patients and the medical community alike may turn to websites of fertility specialists and accept them as true and accurate sources of information. With no regulatory committees in place to police the myriad of websites about infertility, couples are put at risk for obtaining inaccurate or biased information about their infertility problems. The majority of websites that we evaluated mentioned vasectomy reversal, and in general, this information was easily accessible in the site. However, this study also found that many of the websites of male fertility specialists did not mention female factor infertility, and even within this highly-trained group of fertility specialists, conflicting and confusing data exists.

ABSTRACT #19

Varicocelectomy Results in Significant Improvement of Total Regardless of Preoperative Seminal Parameters

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Introduction and Objectives: to determine if preoperative total motile sperm per ejaculate (TME) correlates with outcome of varicocelectomy (Vx).

Materials and Methods: After detailed clinical evaluation for male factor infertility 140 males underwent varicocelectomy repair from September 2003 to July 2008 following AUA Best Practice Guidelines. Semen analyses (SA) were performed preoperatively and at 3 and 6 month intervals postoperatively. A retrospective chart review was performed after IRB approval. Patients were placed into 5 groups by varicocele grade (see table). Additionally, patients were stratified based on their average pre-operative TME (<5 mil, 5-10 mil, >10-20 mil, 20 mil). The primary end point was >50% increase in their post operative TME Patients without any follow up at 3 months, without post operative SA, or those with Y chromosome deletions and/or karyotypic abnormalities were excluded.

Results: Clinical follow-up and SA data was available on 112 patients. See table for complete data. Overall 65% of patients had significant improvement in their seminal parameters. Improvement based by group ranged from 50-90%, with greater improvement seen in patients with grade 3 varicoceles, although there were no significant differences between groups. Based on average preoperative TME across all grades, 77% (33/43) of patients with less than 5 million motile sperm improved, compared to 68%(15/22) with 5-10 million, 42%(8/19) with >10-20 million, and 55%(15/27) for those starting with > 20 million motile sperm.

Conclusion: Varicocelectomy for patients with clinically palpable varicoceles have a significant chance for improvement, regardless of preoperative TME. This is further evidence for repairing clinically palpable varicoceles.

Group		<5 mil	5 to 10 mil	>10 to 20 mil	>20 mil	Total	% Improved of group
Bil G1 10 8.8%	1 Y	5	0	0	0	5	50%
	N	0	1	3	1	5	
		100%	0%	0%	0%		
Uni G2 27 23.9%	2 Y	4	5	3	5	17	63%
	N	2	1	4	3	10	
		67%	83%	43%	63%		
Bil G2 52 46.0%	3 Y	13	5	4	8	30	58%
	N	7	5	4	6	22	
		65%	50%	50%	57%		
Uni G3 12 10.6%	4 Y	6	3	0	2	11	92%
	N	0	0	0	1	1	
		100%	100%	0%	67%		
Bil G3 11 9.7%	5 Y	5	2	1	1	10	91%
	N	1	0	0	0	1	
		83%	100%	100%	100%		
Total per TME group		43	22	19	27	112	
Y		33	15	8	15	73	
N		10	7	11	12	39	
% improved		77%	68%	42%	55%	65%	

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ABSTRACT #20

Case of Performing Electroejaculation in a Non-Spinal Cord Patient

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Introduction: Electroejaculation (EEJ) is an effective method for semen collection in spinal cord injury (SCI) patients who are refractory to other methods such as penile vibratory stimulation. Studies have shown that though the semen quality obtained through penile vibratory stimulation (PVS) is better, EEJ remains the most successful method for obtaining ejaculate and, in some cases, is the only option for spinal cord injury patients. The success of EEJ in SCI patients has inspired its use in novel applications. A report from Israel shows patients without spinal cord injuries who have other barriers to ejaculation are achieving successful semen collection with this method. We

present our case at MCW for EEJ in a non-SCI patient who had moral objections for obtaining sperm through masturbation.

Case Report: EN is 40-year-old neurologically intact male, referred to our clinic for infertility due to delayed ejaculation and decreased potency. He was unable to ejaculate in his wife; however, he admits to having nocturnal ejaculation and, at one event, ejaculation after sexual activity, but still without penetration. The patient is a minister and unwilling to masturbate to collect semen. Infertility work-up was performed including H&P and hormone testing, but a semen analyses, obviously could not be obtained. PVS was also attempted but unsuccessful. EEJ using the Seager method and with the protocol established by Brackett et al was then performed. The sample obtained showed enough sperm to perform IVF/ICSI. The patient did not have any complications or post-procedure difficulties and returned to his work that afternoon.

Conclusion: EEJ for men with and without SCI is a safe and viable method for obtaining a semen sample for the evaluation of fertility and/or for use in advanced reproductive technology in order to achieve pregnancy.

ABSTRACT #21

Voiding Dysfunction in Patients with Dysautonomia

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Introduction: Dysautonomia, or autonomic dysfunction, is a primary neurologic condition resulting from failure of the sympathetic or parasympathetic nervous systems. It has a myriad of clinical presentations including dysregulation of body temperature, orthostatic intolerance, gastrointestinal motility disorders and chronic pain syndromes. Urologically, while sexual dysfunction has been recognized as part of the autonomic dysfunction spectrum, voiding symptoms have been inadequately characterized. We present patients with a known history of dysautonomia referred to our neuro-urology clinic grouped by type of voiding dysfunction.

Methods: Retrospective chart review was performed on all patients seen between 2003 and 2008 in the neuro-urology clinic for voiding dysfunction with the concomitant diagnosis dysautonomia. Patients with other neurologic diagnoses, such a multiple sclerosis or a history of spinal surgery, were excluded from analysis. All patients underwent focused history and physical examination as well as video urodynamic studies. Upper tract imaging by ultrasound or computerized tomography was performed on select patients.

Results: Of 443 patients with the diagnosis of dysautonomia, 37 (8%) were referred for evaluation of voiding dysfunction. Mean age was 47 years (range 12 – 80) and 31/37 (84%) patients were female. Sixteen (43%), 15 (41%) and 6 (16%) patients were diagnosed with detrusor overactivity, detrusor sphincter

dyssynergia and hypocontractile/ acontractile detrusor, respectively. No (0/20) hydronephrosis was noted in patients undergoing upper tract imaging.

Conclusions: A minority (8%) of patients with dysautonomia display voiding symptoms severe enough to warrant neuro-urologic referral. Urodynamically, most patients will exhibit either detrusor overactivity or detrusor sphincter dyssynergia. Upper tract changes were not seen.

ABSTRACT #22

Success of Sacral Neuromodulation Stratified by Age

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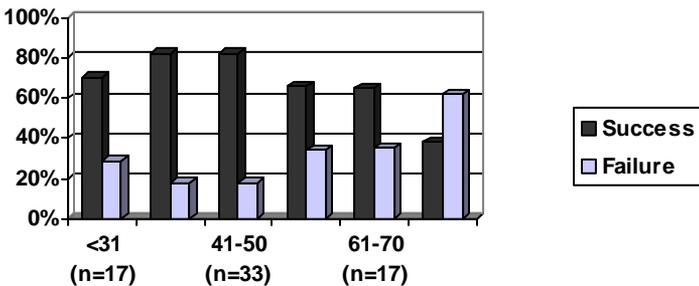
Introduction and Objectives: Sacral neuromodulation has become a viable option for the treatment of refractory urinary urgency/frequency and non-obstructive urinary retention. We present our results of sacral neuromodulation for refractory voiding dysfunction stratified by patient age.

Methods: A retrospective analysis of all patients undergoing staged sacral neuromodulation between 2002 and 2007 was performed. Patient data collected included age at implantation, reason for implantation, gender, medical comorbidities, complications, and success of the procedure. Success was defined as a >50% improvement in voiding symptoms after the test stimulation (stage I) trial period.

Results: Information was available on 142 patients. Overall, success for patients with urgency/frequency, urinary retention and pelvic pain was 78/110 (71%), 18/29 (62%) and 1/3 (33%), respectively. Successful implantation was reported in 70%, 82%, 82%, 66%, 65% and 38% of patients <30, 31-40, 41-50, 51-60, 61-70 and >70 years of age, respectively (see Figure 1).

Conclusions: While overall success rates of sacral neuromodulation for refractory voiding dysfunction are high, efficacy drastically declines when the procedure is performed in patients >70 years of age.

Figure I: Overall outcomes following stage I implantation stratified by decade of age



ABSTRACT #23

Valsalva Voiders are at Increased Risk of Urinary Retention after Urethral Sling Placement for Stress Urinary Incontinence

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Introduction and Objectives: Mid urethral slings have become the gold standard treatment for female stress urinary incontinence (SUI). We retrospectively determined the incidence of postoperative urinary retention in Valsalva and non-Valsalva voiders that underwent mid urethral sling placement. **Methods:** Chart review of all patients receiving mid urethral slings from 2002 to 2007 for the treatment of SUI was performed. Women with concomitant hysterectomy, prolapse repair or elevated (>75cc) preoperative post void residual urine volume were excluded.

Results: Eighty-eight patients were available for analysis – 28 voided by Valsalva and 60 by detrusor contraction. The rate of post operative urinary retention was 21% and 7% in the Valsalva and non-Valsalva groups, respectively ($p<0.05$).

Conclusions: Women who void by Valsalva are at increased risk of urinary retention following mid urethral sling placement.

ABSTRACT #24

The Success of Pelvic Floor Physical Therapy Treatment on Male LUTS and Pelvic Floor Dysfunction

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Introduction: Pelvic floor muscle dysfunction can present clinically with a variety of complaints including pelvic pain, testicular/scrotal pain, penile pain, bladder or urethral pain, and LUTS. Physical Therapy interventions can influence pelvic floor muscle function and therefore decrease the associated pain. Although shown to be effective in treatment of pelvic pain and LUTS, Physical Therapy is not commonly ordered by referring providers. Pelvic floor Physical Therapy educates patients about pelvic floor muscle function and the relationship with urinary, pain, and sexual issues. AIM: to quantify the success of pelvic floor Physical Therapy in the treatment of male patients with pelvic pain and/or LUTS.

Method: A retrospective chart review was performed on 47 patients treated at Froedtert Hospital with pelvic floor Physical Therapy. Chief complaints, objective outcomes, resolution of symptoms, and number of treatment sessions were analyzed.

Results: The mean age of patients treated was 46.9 years. All patients received biofeedback and neuromuscular re-education therapy, 3 patients also received internal pelvic floor myofascial release. The most common chief complaints were testicular pain (21 patients), LUTS (14 patients), and pelvic pain (10 patients). Other complaints include penile pain, urethral pain/urethritis, and ejaculatory dysfunction. 11 patients were excluded from the study because they either had no pelvic floor muscle dysfunction found or there were no follow-up. 30/36 patients reported improvement (83%).

Conclusion: Physical Therapy interventions can improve both pelvic pain and LUTS in male patients presenting with a variety of chief complaints.