RESULTS: Of the 133 phalloplasties performed, 2 patients chose a musculocutaneous latissimus dorsi (MLD) flap, 43 wanted an anterior lateral thigh (ALT) flap, and 88 had a radial forearm (RF) flap. Overall, there were 23 total urethral strictures and 12 fistulas. Of the MLD phalloplasties, 1 of 2 (50%) developed a stricture. No fistulas were noted. Of the ALT phalloplasty patients, 8 of 43 (19%) developed a stricture and 7 (16%) developed fistula. RF phalloplasty patients had lower rates with 14 of 86 (16%) developing strictures and 5 (6%) getting fistulas. All strictures were treated with anastomotic urethroplasty or a first stage Johanson, and all fistulas were repaired with adjacent tissue transfers. With a mean followup of 1.2 years, there was one fistula recurrence requiring repair.

CONCLUSIONS: Phalloplasty is an excellent treatment option for gender dysphoria with an acceptably low urologic complication rate. RF phalloplasties have lower rates of strictures and fistulas. MLD phalloplasties have the highest rate. Anastomotic urethroplasties, first stage Johanson urethroplasties, and adjacent tissue transfers are the treatment of choice for these complications.

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PD16-11
IS THE LASER MIGHTIER THAN THE SWORD? A COMPARATIVE STUDY FOR THE URETHROTOMY
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INTRODUCTION AND OBJECTIVES: The knife is the most common used instrument for a Sachse urethrotomy. Unfortunately there are high rates of recurrences. It is thought that using a laser reduces these recurrence rates. In this study we compare both techniques.

METHODS: We examined 192 patients (all male) in this retrospective study. Between 2010 and 2014, 127 (66,1%) patients were treated with a knife and 65 (33,9%) with a laser (Holmium, Laservision). We used the UREThRAL Stricture score (USS)1 (Table I) for scoring the recurrence rates. In this study we compare both techniques. Postoperative complications were scored using Clavien. Treatment success was stated as no need for intervention. Every intervention was considered a failure, like a recurrence requiring new surgery but also starting Clean Intermittent Catherization (CIC) after surgery.

RESULTS: Mean age in the knife group (KG) was 63 years (95% CI: 60-66), in the laser group (LG) this was 62 years (95% CI: 57-66) (p=0.68). The USS did not differ between both groups (KG 6,0 (95% CI: 5,3-6,7), LG 5,7 (95% CI: 5,4-6,0) (p=0.49). It should be pointed that laser was more often used for patients with a relapse (LG 46,7% (N=32), KG 53,3% (N=32) (p=0.01). All results can be found in Table II.

Between both groups no difference was found in postoperative increase in flow-rate, the percentage postoperative complications (all Clavien II, 1 Clavien III in the KG) or the percentage of failure. Even when looked separately at patients treated for a primary stricture versus those treated for a recurrence, no difference could be found between the KG and the LG; nor in USS, neither in outcomes. Despite the fact that laser was more often used in patients with a recurrence, outcomes were not different when corrected for this item.

CONCLUSIONS: As treatment with laser is more expensive than treatment with a knife, costs have to be taken in consideration in deciding which technique to use in the transurethral treatment of urethral strictures. Furthermore, taking in regard the very poor outcome especially in the recurrence group, open procedures should be considered more often.

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PD16-12
TUBULARIZED BUCCAL MUCOSA FOR LONG SEGMENT URETERAL REPLACEMENT: AN EXPERIMENTAL STUDY IN DOGS
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INTRODUCTION AND OBJECTIVES: Replacement of a long segment of the ureter due to long stricture or severe ureteral trauma is a challenging Problem. We tried to evaluate the feasibility and outcome of the use of tabularized buccal mucosal graft for replacement of a long segment of the ureter in dogs.

METHODS: 12 female mongrel dogs weighing 15 – 25 Kg were used. A buccal mucosal strip 10 – 12 cm long and 1.2 cm width was harvested from the lower cheek. The buccal mucosal graft was cleaned from any underlying tissues. The graft was tubularized around 4 French ureteral catheter, using 6/0 polygalactin sutures except 1cm at each end. A segment of the same length was excised from the iliac ureter. The tabularized buccal graft was anastomosed to a spautulated ureteral ends using interrupted 6/0 polygalactin sutures. An omental flap was mobilized and wrapped around the graft. The omental wrapping was secured by chronic catgut sutures and fixed proximally and distally to the psosas muscle. The ureteral stent was left for three weeks. The animals were followed up for 12 weeks. Intravenous pyelography was done then the animals were sacrificed and the graft was examined grossly and histologically.

RESULTS: Intravenous pyelography revealed that tabularized buccal mucosal graft was patent and permitted adequate and free passage of urine without obstruction. The graft was found to be viable elastic and well vascularized. Histological examination revealed new vasculature and new capillary formation in the buccal mucosal tube. Few myofibroblasts were detected under graft epithelium.

CONCLUSIONS: The use of tabularized buccal mucosa for replacement of a long segment ureteral defect is feasible and allowed free urine transport without obstruction. Omental wrapping is necessary for revascularization of the graft. The technique may be a considerable option for the management of long segment ureteral defects.

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