V11-02
A RANDOMIZED CLINICAL TRIAL ON SAFETY AND EFFICACY OF LOW INTENSITY SHOCKWAVES FOR THE TREATMENT OF ERECTILE DYSFUNCTION – COMPARISON OF TWO TREATMENT SCHEDULES
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INTRODUCTION AND OBJECTIVES: We aim to evaluate the safety and efficacy of low intensity shockwave treatment (LISWT) for erectile dysfunction (ED). Further, we sought to report 1 month and 3 months post-treatment follow-up data from an ongoing phase II randomized clinical trial.

METHODS: Men with ED (n²=730) between the ages of 30 and 80 years who had a baseline International Index of Erectile Function questionnaire (IIEF-EF) score between 11-26, total testosterone between 300 and 1000 ng/dl in AM, phosphodiesterase inhibitor washout period of at least 4 weeks and had 1 month follow-up data were included in this analysis. We excluded patients with previous radical prostatectomy, extensive pelvic or back surgery, HbA1c > 7.5%, or in use of antidepressants. Patients were randomized in a 1:1 ratio into two treatment schedules for a total number of 3600 shocks using the Direx Renova LISWT device. Group A received 720 shocks on a five-day consecutive treatment schedule for one week and group B received 600 shocks every other day on a 6 days schedule for two weeks. Subjects reported the IIEF and Erection Hardness Score (EHS) questionnaires at baseline, 1 month and 3 months follow up.

RESULTS: Mean +/-% IIEF-EF score at base line was 17.5 +/- 0.8 for group A, and 17.7 +/- 1.1 for group B. 1 month follow-up group A revealed an increasing in the IIEF-EF score from 17.5 +/- 0.8 to 20.1 +/- 1.5 (p = 0.10). However, group B had a lower increase in the IIEF-EF score at 1 month follow up 17.7 +/- 1.1 to 19 +/- 1.1 (p=0.15). Mean +/- IIEF-EF score after three-month follow-up was 20.8 +/- 2.5 and 22.1 +/- 1.3 for group A and B respectively. Group A and B had a significant increase in the EHS-EF score at 1 month follow-up (p<0.001 and p<0.02 respectively). However, no significant difference was found on the mean +/- EHS-EF score at 3 months follow-up despite an increase in the EHS-EF score in both groups (3.1 +/- 0.2 and 3.1 +/- 0.16).

CONCLUSIONS: Ongoing Phase II clinical trial of the effect of LISWT on ED revealed a promising effect on recovery of the erectile function at 3 months follow-up. In this interim analysis, a clinically and statistically relevant effect of LISWT was observed. Long-term follow-up is needed to determine efficacy of shockwave therapy for erectile dysfunction.

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V11-03
CORRECTING PEYRONIE’S CURVATURE WITH PLAQUE INCISION AND GRAFTING USING TEMPORALIS FASCIA
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INTRODUCTION AND OBJECTIVES: Plaque incision and grafting is an ideal technique to correct severe acquired penile curvature. Though there is no consensus on the best graft material, many options are available. The graft should allow for preservation of erectile function, resist infection, be watertight, have minimal contraction, and feel natural. Using an IRB-approved database, we present our contemporary experience of 93 patients with Peyronie’s curvature treated with plaque incision and grafting using a temporalis fascia free graft.

METHODS: With the patient in supine position, a circumcising incision is made and the penis is degloved to the base of the penis. A tourniquet is placed and an artificial erection created with normal saline. The area of maximal curvature is identified and the tourniquet is released. The neurovascular bundle is identified and sharply dissected within Buck’s fascia and elevated from the tunica. Concurrently, temporalis fascia is harvested from above the left ear by a second surgical team. A template is created based on the size and shape of the anticipated defect. After graft preparation, the tourniquet is replaced and a full-thickness tunical incision is made at the point of maximal curvature. A modified Y, H, or transverse incision is used depending on the degree and angle of curvature. With the tunical defect exposed, the graft is sutured into the tunica albuginea using 5-0 suture. The tourniquet is released as soon as possible and the repair is inspected to ensure that it is watertight. The skin edges of the circumcission are approximated using absorbable suture. On post-operative day 5, the patient is instructed to gently massage the graft. 4 weeks after surgery the patient is permitted to resume sexual activity and is advised to use a vacuum-erection device daily to restore elasticity to the penis.

RESULTS: No high-grade intraoperative complications were observed. After a mean follow-up of 7.91 months (0.87 – 46.93 months), correction of penile curvature was achieved in 87 (93.5%) patients. 6 patients complained of residual curvature and underwent additional plication surgery. 5 patients underwent subsequent IPP placement. No donor site morbidity was observed including infection, scarring, swelling, or lymphedema.

CONCLUSIONS: Free grafting using temporalis fascia offers achieves excellent long-term functional and cosmetic outcomes with minimal donor-site morbidity.

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V11-04
INFLATABLE PENILE PROSTHESIS IMPLANTATION POST PHALLOPLASTY
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INTRODUCTION AND OBJECTIVES: Female to male gender confirmation surgeries are more common every year. Once the neophallus has been constructed, the implantation of a penile prosthesis grants optimal functionality. Patients often choose the Inflatable Penile Prosthesis (IPP) over the malleable prosthesis, as the former allows for a more natural erection. In this video we present our technique for inflatable penile prosthesis implantation after gender confirmation surgery.

METHODS: A 4 cm transverse incision was made just below the level of the pubic bone. Two grooves were created in the peristome of the pubis to anchor the prosthesis and 0 polypropylene stay sutures were placed. Two cavities were created with sharp dissection in the tissue within the neophallus and serially dilated to #10 Hegar. The Furlow instrument was passed distally into the neophallus, and the length of the cylinder needed for the prosthesis was measured to be 16 cm. The space for the 65 cc reservoir was created by developing the retropubic space with the aid of a nasal speculum. For placement of the left testicular prosthesis, a transverse incision was made in the upper portion of the left hemiscrotum and a pouch for the prosthesis was created with blunt and sharp dissection. Dermis allograft was tubularized around a 10.5 Hegar, to create the corpora cavernosa. The Furlow device with the Keith needle was used to place the dermis allografts over the two prosthetic cylinders. The Furlow was used again to guide the cylinders into the dilated tissue within the neophallus. At this point, the stay sutures were threaded through 0.5 back tip extenders bilaterally to anchor the cylinders to the peristome. The prosthesis pump was then placed in the right side of the scrotum, contralateral to the vascular pedicle of the neophallus.

RESULTS: The operative time was 120 minutes. EBL was minimal. Patient was discharged on postoperative day 1. There were no postoperative complications. After two months, the patient was able to have satisfactory intercourse. Out of ten female to male gender confirmation surgeries this year all of them had an IPP placement and there were no complications.

CONCLUSIONS: Inflatable penile prosthesis placement is the ultimate step in female to male gender confirmation surgery. Proper