Title

PD42-05 DOES PENOSCROTAL DECOMPRESSION OUTPERFORM CORPOROGLANULAR TUNNELING FOR SURGICAL MANAGEMENT OF PROLONGED ISCHEMIC PRIAPISM?

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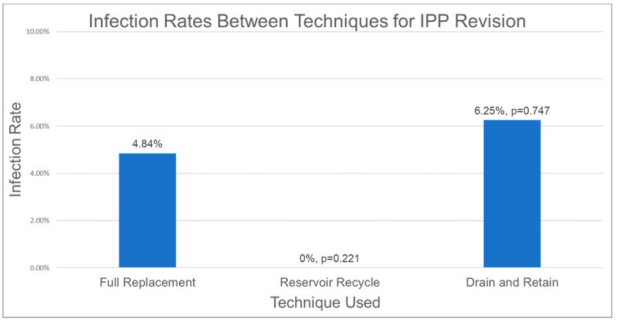
METHODS: We performed a retrospective chart review of our single-surgeon IPP database between 2007-2022 to identify patients who underwent revision. Cases were stratified by reservoir management technique. Patients who had undergone at least one follow-up visit and had complete documentation regarding reservoir handling were included. Reservoir-related complications necessitating surgical intervention such as infection, mechanical failure, and non-mechanical failure were compared between the three groups using a chi-square test. Mean follow-up duration, time to revision, and operative time were assessed using a Student's T-test.

RESULTS: Among 140 patients who met inclusion criteria, 62 underwent full reservoir replacement, 48 had drain and retain, and 30 had reservoir recycling. When compared to full replacement, retained and recycled reservoir groups had similar mean follow-up duration, time to revision, and intraoperative time (Table 1). The rates of infection, mechanical failure, non-mechanical failure, and revision were similar for the retained and recycled groups when compared to the full replacement group. There were no instances of reservoir herniation or reservoir-related bowel complications between the three groups.

CONCLUSIONS: There was no difference in reservoir-related complications when comparing the drain and retain or reservoir recycle groups to the full replacement group. Both the drain and retain as well as reservoir recycling techniques are safe and effective management options in IPP revision surgery.



	Full IPP Replacement (n=62)	Drain and Retain (n=48)		Reservoir Recycle (n=30)	
			p-value		*p*-value
Follow Up Duration, months (mean, SD)	13. 3 +/- 22	21.7 +/- 35	0.144	12.8 +/- 18	0.907
Time to Revision, months (mean, SD)	25.8 +/- 21	27.0 +/- 43	0.101	22.4 +/- 20	0.81
OP Time, minutes (mean, SD)	88.6 +/- 28	83.9 +/- 25	0.357	87.0 +/- 32	0.806
HSM Reservoir Location (no.,%)	56 (90%)	40 (91%)	0.919	18 (90%)	0.966
Post-Operative Infection	3	3	0.747	0	0.221
IPP Device Revisions					
Mechanical Failure	2	1	0.292	4	0.248
Non-Mechanical Failure	4	8	0.292	2	0.248

Source of Funding: N/A

PD42-04

BLOOD THINNERS: DO THEY NEED TO BE HELD FOR IPP SURGERY?

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INTRODUCTION AND OBJECTIVE: Inflatable penile prosthesis (IPP) placement on active anticoagulation (AC) is controversial. Techniques utilized to decrease complications include use of malleable implant, partial inflation of IPP for hemostasis, and placement of drain; however risk and benefits must be weighed. We sought to assess outcomes of IPP in men on AC in a multi-institutional study.

METHODS: Data from 3 high-volume implant centers was retrospectively analyzed. Demographics, comorbidities, secondary procedures, drain placement/output, and complications were recorded. Aspirin was excluded as it is not routinely held. Center 1 utilizes a penoscrotal approach without drain placement, center 2 a penoscrotal approach with drain placement (removal when output $<$50 mL/8 hours), and center 3 an infra-pubic approach with drain for 3 days.

RESULTS: 202 patients were continued on AC throughout surgery. 112 patients were on clopidogrel, 35 warfarin, 38 apixaban, 1 enoxaparin, 15 rivaroxaban, and 1 on combination therapy with clopidogrel and enoxaparin. AC requirement included peripheral vascular disease (55%), CHF (11%), cardiac stents (11.6%), DVT/PE/history of thrombosis (7%), atrial fibrillation (11%), cardiac valves (2.2%), stroke (1.3%), and preventive (0.9%). Nine patients on AC (3.98%) experienced complications including 4 significant events (1.9%): 1 major retropubic bleed requiring transfusion, 3 IPP infections and 5 minor events: 3 minor hematomas, 1 minor wound dehiscence and 1 CT negative stroke event. Drain outputs for center 3 averaged 113 ml, 81 ml, and 30 ml of output per day respectively with a total average output average of 223 ml and experienced no hematomas nor infections. Drain output for center 2 averaged 121 ml with the majority or patients having the drain for only one day. Drain output was significantly higher than historical non-AC controls (121 vs. 72 ml p$=$.001) but there was no difference in hematoma rate. Three hematomas and 1 infection occurred in this group. AC type, revision surgery, scrotoplasty, or reservoir technique did not affect outcomes nor drainage (p$>$.05). Complication rate (IPP infection and hematoma rate) where not different when compared to large cohorts from respective institutions.

CONCLUSIONS: In high-volume implant centers, major complication rate of 1.9% occurred in IPP patients on AC. Although IPP is feasible in this patient population, drain for 3 days and submuscular reservoir placement may be indicated. In most, elective IPP surgery should be delayed until it is safe to discontinue anticoagulation.

Source of Funding: None

PD42-05

DOES PENOSCROTAL DECOMPRESSION OUTPERFORM CORPOROGLANULAR TUNNELING FOR SURGICAL MANAGEMENT OF PROLONGED ISCHEMIC PRIAPISM?

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INTRODUCTION AND OBJECTIVE: Prolonged ischemic priapism (PIP) presents a rare and challenging urological condition, often requiring advanced surgical maneuvers for resolution. We sought to evaluate current practice patterns in the management of this challenging condition using a multi-institutional survey.

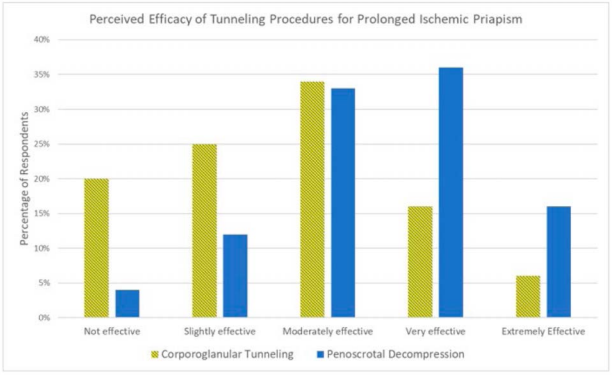
METHODS: A 38-question, web-based survey was distributed to clinically active urologic surgeons including members of the Society of Genitourinary Reconstructive Surgeons (GURS) and the Sexual Medicine Society of North America (SMSNA). PIP was defined as priapism duration of at least 24 hours prior to presentation. Questions highlighted experience with and perceived efficacy of adjunctive maneuvers including distal shunting, corporoglanular tunneling (CGT) and penoscrotal decompression (PSD). Also queried were surgeons' impressions of the prevalence of erectile dysfunction after priapism surgery.

RESULTS: One hundred fifteen responses were received following survey distribution. Tunneling procedures (CGT and PSD)

were the favored first-line intervention for PIP over implants (80/114 tunneling vs. 11/114 implant, p<.001). Respondents were more likely to have performed CGT than PSD (110/113 for CGT vs. 74/112 for PSD, p<.001), but among those who had performed both, PSD was felt to be more than twice as effective at resolving PIP (33/63, 52% Very or Extremely Effective for PSD, vs. 13/64, 20% for CGT; p<.001, Figure 1). For patients with recurrent priapism after CGT, PSD was the preferred salvage procedure for 46% of surgeons (46/99) while immediate implant was favored by 40% (40/99, p=.390). Regarding sexual function, a similar number of respondents who had performed both tunneling procedures felt that at least half of patients regained adequate sexual function after either CGT or PSD (27/61, 44% vs. 25/60, 42%; p=.773).

CONCLUSIONS: PSD is perceived by surgeons as more effective than CGT for prolonged ischemic priapism and is commonly chosen as a salvage procedure when CGT fails. Many surgeons feel that patients regain erectile function after tunneling procedures, avoiding the need for expensive prosthetics.

Figure. Perceived Efficacy of Tunneling Procedures for Prolonged Ischemic Priapism



Source of Funding: N/A

PD42-06

EFFECTS OF INTRAVESICAL BOTULINUM TOXIN TYPE-A INJECTION LOCATION ON SYMPTOM SCORES AND SEXUAL FUNCTIONS IN FEMALE PATIENTS WITH A DIAGNOSIS OF REFRACTORY BLADDER PAIN SYNDROME/INTERSTITIAL CYSTITIS: A RANDOMIZED, PROSPECTIVE STUDY

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INTRODUCTION AND OBJECTIVE: To determine the effect of Intravesical Botulinum Toxin type-A (BTX-A) treatment with trigon included and trigone sparing on symptoms and sexual function in female patients diagnosed with Bladder Pain Syndrome/Interstitial Cystitis (BPS/IC) who did not benefit from conventional treatments.

METHODS: Patients with BPS/IC who were treated with hydrodistension+BTX-A were enrolled in the study between January 2020 and April 2022. Using the stratified randomization technique, patients were randomly randomized to one of two groups: hydrodistension+trigone sparing injection (Group-1) or hydrodistension+trigone-included injection (Group-2). The study comprised a total of 27 patients. The patients were evaluated with VAS, ICSI, ICPI, FSFI questionnaires, and 3-day voiding diaries, voiding tests, and residual urine tests (uroflowmetry and residue determination) in the preoperative period and in the postoperative first and third months.

RESULTS: The study comprised a total of 27 patients, 14 from Group-1 with a mean age of 40,9 (±9,25) and 13 from Group-2 with a mean age of 41.7 (±10.3). Preoperative VAS, ICSI, ICPI, and FSFI scores for 27 patients were 8.95±1.39; 16.21±2.94; 14.38±2.27 and 15.92±3.73, respectively. VAS, ICSI, ICPI, and FSFI scores were 3.47±2.94; 7.14±3.97; 6.47±3.95 and 22.41±5.02 at the first postoperative month, respectively. It was 2.69±3.18; 5.79±5.08; 5.79±4.95 and 24.41±6.06 in the third month postoperatively. Treatment led to statistically significant improvements in all four variables (p<0.001). While significant improvement was observed with treatment in both groups, no difference was found between the two groups in terms of treatment results (p: 0.89; p: 0.341; p: 0.488 and p: 0.706, respectively). In total, two patients had urinary tract infection in the postoperative period and one patient had retention, but there was no difference between the two groups in terms of adverse effects (p>0.05).

CONCLUSIONS: Intravesical BTX-A treatment is an effective and safe treatment in female patients with BPS/IC unresponsive to conventional treatments. The treatment also contributes positively to sexual functions. The inclusion of trigone in the injections makes no difference to the treatment response.

Source of Funding: none

PD42-07

OUTCOMES RELATED TO INFLATABLE PENILE PROSTHESIS (IPP) RESERVOIR REMOVAL: A 7-YEAR MULTI-CENTER EXPERIENCE

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INTRODUCTION AND OBJECTIVE: The 3-piece IPP is the most widely used device for erectile dysfunction refractory to medications, containing a reservoir inserted into the Space of Retzius (SOR) or an alternative/ectopic space (AES). Indications for removal of the reservoir include malfunction, malposition or infection. In revision cases without infection, reservoir removal is sometimes optional. We review outcomes and complications specifically related to reservoir removal from a large multi-institutional series.

METHODS: We retrospectively reviewed databases at 6 institutions over 7 years. Patients with artificial urethral sphincter, urethral sling or Mini-jupette were excluded. Outcomes and complications related to IPP reservoir removal were analyzed. Data were collected but only reservoir-related complications at surgery were included. Data were compared between SOR and AES cohorts to evaluate differences with $\chi 2$, with significance at $p<0.05$.

RESULTS: Of 215 cases, there were 172 SOR (80%) and 43 AES (20%) reservoirs. Mean patient age was 65.3 years old. 131 (60.9%) procedures were due to malfunction, 49 (22.8%) were due to malposition of an IPP component, and 35 (16.3%) were secondary to infection. Among those retained (N=44, 20.5%), reasons included reuse, avoiding surrounding structure damage, unspecified, and difficult dissection. Among those removed (N=171), 15 (8.8%) required a counter-incision (6 in SOR and 9 in AES). $\chi 2$ to determine statistical difference between those removed from SOR and AES found a p=0.00059, indicating significant difference in the need for a counter-incision those groups. Complications included bladder perforation (N=1) in the SOR group, and an avulsion of the epigastric vessels requiring abdominal exploration (N=1) in the AES group. $\chi 2$ to determine statistical difference when comparing SOR and AES complications was p=0.365, indicating no significant difference between groups.

CONCLUSIONS: Removal of an IPP reservoir remains safe with few complications. Surgeons should be aware of the inferior epigastric vessels during removal in an AES or be willing to perform a counter incision to avoid injury to surrounding structures. Surgeons should obtain preoperative imaging to identify the specific location of the reservoir and adjacent anatomy. This is the first and largest multi-institutional study reviewing outcomes related to reservoir removal during IPP revision or removal surgery.

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