ventral approach but one single patient had fistula at the voiding uretrography.
Discussion: We report very good results for treatment of FUS with the management of the distal urethral stricture with a dorsal urethroplasty and the proximal US with ventral urethroplasty. experience is most appropriate.

SC63 Minimal invasive technique for dorsal female urethroplasty by asopa procedure

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Aim of the study: During the last years, urethral surgery is linked to the concept of urethra-sparing. We present a minimal-invasive technique for female urethroplasty without mobilization of the urethra.
Materials and methods: This is a retrospective study based on female patients affected by medium-distal urethral stricture who underwent urtehroplasty between 2017 to 2018. The cause of stricture was undetermined in 5 pts and iatrogenic in 5 others. All patients have undergone multiple urethral dilatations. The preoperative clinical evaluation was based on: medical history, physical examination, urine culture, uroflowmetry (Qmax), voiding cystouretrography or voiding urography. Cystoscopy was executed before surgery to confirm the diagnosis of stenosis and to evaluate the exact position. The surgical procedure was executed in lithotomic position. A sensor guide wire was inserted in the urethra that was incised on the midline in the context of the stricture and inspected using a Gorget tool. The dorsal plate of the urethra was incised and an elliptical raw area was created over the peri-urethral tissue where a free full-thickness graft of buccal mucosa was sutured. A Foley 14 Ch was left in place.
Results: Ten patients were included in the study. Median age was 48 years (range:30–68). Median preoperative Qmax was 10 (range 4–15). In average the operative time was 1 hour. No perioperative complications occurred. Hospital stay was no longer than 2 days. Catheter was removed after 3 weeks without any cistourethrography control because of the low risk of urethral fistulae in absence of urethral mobilization. Four subjects experienced irritative symptoms after catheter removal that was treated conservatively. After the removal of the catheter, all patients were followed up by a series of uroflowmetries (median Qmax 21: range 16–30) with post voiding residual at 30, 60, 90 days. Median postoperative Qmax was 30 ml/s (range 25–42) at 30 days, median Qmax was 28 ml/s (range 24–45) at 60 days, median Qmax was 28 ml/s (range 22–43) at 90 days. In case of dorsal urethral reconstruction without need of urethral dissection, complications such as risk of bleeding, damage to clitoral structures and stress incontinence as well as other neurosensory complications are uncommon with the dorsal repair. In our series none of these problems was identified.
Discussion: The minimal invasive dorsal sagittal urethrotomy approach with dorsal free graft urethroplasty preserves the urethra, avoiding urinary incontinence. This is due to the anatomical distance from the urethral sphincter. Uroflow results suggest good therapeutic results. This experience suggests the feasibility of the technique with high success rates.

SC64 Uventa urethral stents: Are we taking a step forward? the first clinical series

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Aim of the study: Aim of this study is to describe first clinical results of temporary placement of UVENTA urethral stent in the treatment of benign urethral disorders.
Materials and methods: UVENTA urethral Stent (Taewoong Medical) is a temporary self expandable covered metallic stent. A nickel-titanium coil is completely covered by a silicone coat in the inner and in the outer part. Anti-migration system and different radial force distribution are the two main innovations. 4 anchors are located on the distal end of the stent aiming to reduce migration and the radial force is maximum in the center of the stent with progressive reduction on the tips. This is a retrospective evaluation of UVENTA stent placements for urethral diseases (stricture and fistula) in two urological Centers. Success was defined as the lack of stricture on urethroscopy performed with a 16 ch flexible cystoscope 6 months after stent removal and no need fo further procedure; in case of urethral fistula the absence of leakage on urethrogram was considered. Patients with at least 6 months of follow-up after stent removal were included.
Results: 18 patients underwent UVENTA stent placement between 2016 and 2018. Pre-, intra- and post-operative data are reported in Tab 1. No specific intraoperative events were recorded. One patient reported urethral pain related to the stent in the first month. Three patients had urinary infection treated with antibiotics. 3 out of 4 stents placed on the bladder neck migrated in the bladder two, three and six months after implantation; none of the other stents migrated. At removal no significant incrustation, stone or tissue ingrowth were noted. New proximal or distal strictures with stent in situ were never noted at stent removal. Migrated stents were removed without any problems. All procedures were easy and quick. Median follow up is 9,5 months (6–24). Considering strictures overall success rate is 73% (11/15): 82% for bulbar urethra (9/11) and 50% for bladder neck (2/4). Urethral fistula was repaired in all cases (3/3).
Discussion: UVENTA urethral stent showed success rate similar to other covered temporary stents in the treatment of recurrent bulbar-membranous urethral strictures in the short-medium follow up. Significant achievements are the absence of migration and damage on healthy mucosa, with no onset of new strictures. Further cases are needed to confirm these results and to explore the effective role in the treatment of vescico-urethral strictures and urethral fistulas.

SC65 Repair of sphincter urethral strictures preserving urinary continence: Surgical technique and outcomes

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Aim of the study: The incidence of urethral stricture after transurethral resection of the prostate (TURP) is estimated to range between 2.2% and 9.8% and can occur in different urethral sites, including proximal bulbar tract in the close proximity to the membranous urethra and the urethral sphincter, which we define as sphincter strictures. Because of their site and the bladder neck compromised by a prior BPH surgery, their surgical repair represents a challenge due to the risk of urinary

Pt	Urethral disease	Site of disease	Cause	Previous surgery	Kind of stent (mm)	Bladder drainage	Complications	Migration	Site of migration	Indwelling time (months)	Follow up (months)	Recurrence
1	Stricture	Bladder neck	RARP + RT	U-thomy (4)	60x16	SP tube	None	Yes	Bladder	3	9	Yes
2	Stricture	Bladder neck	RRP	U-thomy (3)	40x16	None	None	Yes	Bladder	6	6	No
3	Stricture	Bladder neck	RARP + RT	U-thomy (5)	40x16	SP tube	SP displacement	No	-	2	7	No
4	Stricture	Bladder neck	RRP	U-thomy (2)	40x16	SP tube	none	Yes	Bladder	2	7	Yes
5	Stricture	Bulbar	Trauma with incomplete fracture	U-thomy (3)	60x16	none	none	No	-	12	8	No
6	Stricture	Bulbar	Trauma with incomplete fracture	U-plasty	60x16	none	UTI	No	-	12	24	No
7	Stricture	Bulbar	Trauma with complete fracture	U-plasty	40x16	none	none	No	-	12	11	Yes
8	Stricture	Membranous-bulbar	TURP	U-thomy (1)	40x16	none	none	No	-	6	10	No
9	Stricture	Bulbar	TURP	U-thomy (1)	40x16	SP tube	Urethral pain	No	-	6	9	No
10	Stricture	Bulbar	Exeresis of urethral diverticulum	U-plasty	40x14	none	none	No	-	6	6	No
11	Stricture	Bulbar	Catheter*	U-thomy (1)	40x16	none	none	No	-	6	24	No
12	Stricture	Bulbar	Idiopatic*	U-thomy (2)	40x16	none	UTI	No	-	6	21	No
13	Stricture	Membranous	Catheter*	U-plasty (1)	60x14	none	none	No	-	6	20	No
14	Stricture	Bulbar	Catheter**	U-thomy (3)	40x16	none	none	No	-	6	7	No
15	Stricture	Bulbar	Idiopatic	U-plasty U-thomy	40x16	none	none	No	-	11	6	Yes
16	Fistula	Recto-urethralis	Prostatitis	None	60x16	none	none	No	-	4	15	No
17	Fistula	Recto-urethralis	Prostatitis	None	40x16	none	none	No	-	5	12	No
18	Fistula	Ischial-urethral	Paraplegy	None	40x16	none	none	No	-	6	18	No

Tab.1: pre, intra and post-operative results. * after renal transplant, ** patient with kidney-pancreas transplant with pancreatic exocrine diversion to the bladder. U-thomy: urethrotomy. U-plasty: urethroplasty. SP tube: suprapubic tube. UTI: urinary tract infection

Figure: (abstract: SC64).

incontinence. We described a surgical technique to treat these strictures preserving urinary continence in patients with incompetent bladder neck. The aim of this study was to investigate the clinical outcome of surgical repair of post-TURP sphincter urethral strictures and to report the rate of post-operative urinary continence.

Materials and methods: An observational retrospective descriptive study was conducted on patients affected by post-TURP sphincter urethral strictures, in two centres, from 2002 to 2017. Only fully continent patients after TURP, HOLEP or TUIP who subsequently developed sphincter strictures were included. A positive anamnesis for urethral strictures of different aetiology or incomplete follow up represented exclusion criteria. The primary outcome was treatment failure, defined as the need for any post-operative instrumentation. Secondary outcome was post-urethroplasty urinary continence. Stricture recurrence or postoperative incontinence were classified as failure. Preoperative evaluation consisted of clinical examination, urine culture, post-voiding residual (PVR) volume, retrograde urethrogram, voiding cystourethrogram (VCUG), sonourethrography, urethroscopy. One month after surgery a VCUG was performed and the catheter removed. Follow up visits with uroflowmetry and PVR volume were scheduled every 6 months for at least 1 year. Urinary continence was evaluated in different body position and through patients' reports. In case of incontinence, urodynamics were performed.

Results: Overall, 69 patients who underwent TURP, HOLEP and TUIP were included. Median age was 67 years; median stricture length was 4 cm (range 1–7 cm). Median follow-up was 52 months. Out of 69 patients, 55 (79.7%) were classified as success and 14 (20.3%) as failure. Out of the 14 failures, 11 (78.6%) were due to recurrent strictures, and 3 (21.4%) to post-operative incontinence.

Discussion: To preserve urinary continence in patients with post-TURP sphincter urethral strictures is essential to respect the anatomy of this area during surgery: a full circumferential dissection of the proximal urethra can lead to sphincteric damages and loss of continence. The use of modified ventral onlay graft urethroplasty, adopting non-aggressive steps, is a suitable surgical technique for repair of sphincter urethral stricture in patients who underwent BPH transurethral surgery. This technique provided 79.7% success rate in terms of urethral patency, and 95.6% of post-operative urinary continence.

SC66 Prerectal-Transperineal approach for treatment of recurrent anastomotic strictures after radical prostatectomy

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Aim of the study: We aim to describe a safe reanastomotic procedure for recurrent bladder neck contracture following radical prostatectomy. The prerectal-transperineal approach allows an easier access to the stenotic vesicourethral anastomosis, a better mobilization of the bladder neck and a tension free reanastomosis.

Materials and methods: 12 patients suffering from bladder neck contracture after radical prostatectomy were enrolled between may 2014 and september 2018. All subjects were placed in simple lithotomy position and an inverted-U incision was made 1 cm above the anus. Thus, the incision of the central tendon of the perineum and the gain of the ischiorectal fossae allows direct access to the stenotic anastomosis. Since the bladder neck is easily mobilized and the distal bulbar urethra is isolated (by making a vertical median skin incision)