requirements (in terms of equivalent of the diclofenac), in group 1 was less (t = 2.31, p < 0.05) than in group 2 (121.6 ± 19.13 mg and 198.2 ± 14.30 mg respectively).
Conclusion: Totally tubeless PNL in patients with existing nephrostomy tube shows reliably better operation time, hospital stay duration and analgesia requirements. In this regard, to patients with an existing nephrostomy tube, as an alternative to the standard PNL, we can recommend totally tubeless PNL.

GUA-22 Results of primary TRUS prostate biopsy depending on PSA level and prostate mpMRI data

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Background: In the success of treatment of prostate cancer, timely diagnosis of its localized form is very significant. In this issue, prostate biopsy plays a key role. However, a high percentage of negative results of the primary biopsy raises, many questions are standing to researchers regarding the improvement of indications for this invasive procedure.
Objective: To analyze the results of primary transrectal prostate biopsy, depending on the level of total PSA and mp-MRI data of the prostate.
Material and methods: The analysis of the results of 217 primary multifocal biopsies of the prostate performed according to medical indications, according to negotiability of patients to RSSPMCU in the period 2016–2019y. Of these, 203 patients underwent a primary biopsy at once, 14 patients after performing a multiparametric MRI of the prostate on a Philips Ingenia 1.5 Tesla machine with an assessment PIRADS-v2 scale (Prostate imaging reporting and data system).
The average age of patients was 68.94 ± 0.54 (years), the volume of the prostate gland (gland + adenoma) was 72.69 ± 2.13 (cc), while the average level of total PSA in serum was 29.27 ± 0.08 (ng/ml). Preparing patients for biopsy included: discontinuation of antiplatelet drugs before 7 days, the start of ciprofloxacin administration 500 mg × 2 times a day before the procedure. The material for the study was taken TRUS guided, under local anesthesia, by using a BIP-high speed multi biopsy gun, biopsy needle 18–20 g × 20 cm, tissue took from 10 sites of the prostate gland, with coverage of the peripheral and apical zones. In 14 patients whom performed preoperatively mp-MRI, besides standard 10 shots performed additional 4 to 6 shots from suspicious zone.
Results: Out of 203 primary biopsies, adenocarcinoma was verified in 145 (71.4%) patients, whose prostate volume was 74.08 ± 2.12 (cc), in 58 (28.6%) – BPH, volume 68.73 ± 2.14 (cc), Table 1.

Table 1
Results of primary prostate biopsy from the level of total PSA (n = 203)

PSA level, (ng/ml),	Total number of patients, n,	Number of adenocarcinomas detected (%)	Number of patients with G1–2 (% of identified)	Number of patients with G3-4 (% of identified)
5–10	17	2 (11.2)	–	2 (100)
11–20	52	30 (57.7)	13 (43.3)	17 (56.7)
21–30	47	36 (76.6)	7 (19.4)	29 (80.6)
31–40	41	37 (90.2)	7 (18.9)	30 (81.1)
41–50	25	22 (88.0)	2 (9.1)	20 (90.1)
51–60	11	9 (81.8)	1 (11.1)	8 (88.9)
61–100	10	9 (90.0)	–	9 (100)

Analysis of morphological study results of the prostate biopsies, depending on the level of total PSA showed that with PSA levels of 5–10 ng/ml, 88.8% had a negative result, 5–20 ng/ml had 53.6%, 5–30 ng/ml – 42.5%.
Given the high negative result of primary biopsy in patients with PSA level up to 30 ng/ml, 14 patients who did not suspect c-r according to DRE and TRUS, performed m-p MRI of the prostate (8 of them with a PSA level of 5–20 ng/ml, 2 of 21–30 ng/ml and 4 of them 31 ng/ml and above), followed by performing a primary biopsy.
In 4 patients with total PSA levels above 31 ng/ml, adenocarcinoma was detected (100%); in 2 patients with PSA level of 21–30 ng/ml (PIRADS 2, PIRADS 3) – revealed BPH; of 8 patients with PSA levels of 5–20 ng/ml in 1 (12.5%) revealed a neuro-endocrine adenocarcinoma (with a total PSA level of 5.92 ng/ml, mp-MRI was rated according to the PIRADS 5 scale). Of 9 (90.0%) patients with a PSA level of 5–30 ng/ml, whom BPH was detected (mean PSA was 17.80 ± 1.40, prostatic volume of 73.8 ± 11.8, according to mpMRI PIRADS 2 – was in 4, PIRADS 3 – in 5 patients), 5 patients underwent TURP. A postoperatively histological examination confirmed the BPH.
Conclusions: Thus, after the primary transrectal biopsy of the prostate among patients with a total PSA level of up to 10 ng/ml, adenocarcinoma was detected in 2 (11.8%), with a PSA level above 11 ng/ml in 143 (76.9%). Of the 145 patients who had verified prostatic adenocarcinoma, the patients were 61–70 years old, of them G1-2 were diagnosed in 30 (20.7%) and G3-4 in 115 (79.3%). Of the 10 patients with a PSA level of 5–30 ng/ml, 9 (90%) with points on the PIRADS grade (2 and 3) had BPH. In our opinion, the main question which patients after mp-MRI may not perform a biopsy remains open.

GUA-23 Effect of 5-α reductase inhibitors on the results of transuretral resection of benign prostate hyperplasia

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Objective: Comparative evaluation of the results of the TUR of BPH in patients who have taken the alpha blockers for a long time with patients who took alpha blockers and finasteride 5 mg/day for more than 1 year.
Material and methods: This study included 120 patients who was underwent monopolar TUR of BPH. We carried out a prospective analysis of the results and the patients were divided into two groups. In 1st group we included 80 patients who in anamnesis had not receive treatment for BPH or for various periods received standard therapy with alpha adrenergic blockers. The average age was 67.8 ± 4.06. The 2nd group included 40 patients who, in addition to alpha adrenergic blockers, took finasteride at 5 mg/day for more than 12 months, whose age was 68.6 ± 1.44 (P > 0.05). The volume of the prostate in patients with the 1st group was 57.8 ± 2.19 cm^3, in the 2nd – 58.2 ± 2.34, P > 0.05. All patients were performed monopolar TUR of BPH according to standard procedure under spinal anesthesia.
Results: The time of resection and the duration of intervention in patients of the first and second groups was 54.5 ± 1.30 and 41.2 ± 1.37 (min) respectively, P < 0.05. The volume of intraoperative blood loss in groups of patients was 269.9 ± 10.17 (ml) and 262.3 ± 12.37 (ml), P > 0.05.
In the postoperative period, among patients of the 1st group, only 38 (47.5%) complications were observed (TUR syndrome in 2, postoperative intensive staining of urine with blood in 23 (6 of them had repeated coagulation of bleeding vessels), complicated UTI was observed in 9, in 2 developed a urethral stricture, 2 had a bladder neck stricture). Among patients of the 2nd group, only 9 (22.5%) complications were observed (in 5 – hematuria, in 4 – complicated UTI), P < 0.01.

Postoperative hospital stay among patients 1st group amounted to 4.5 ± 0.19 versus 3.3 ± 0.09 in the 2nd group, P < 0.05.
Conclusion: In the group of patients who took Finasteride 5 mg/day for more than one year, the frequency and severity of bleeding and infectious and inflammatory complications after TUR was significantly less than among patients who did not take Finasteride. Consequently, in this group of patients no addition interventions were performed, and no post-inflammatory sclerotic complications were observed.

GUA-24 Endoscopic recanalization of the cicatricial urethral obliteration

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Background: The complexity of endoscopic treatment of urethral obliteration, unlike stricture, lies in the complete absence of the urethral lumen with its replacement with dense scar tissue and the limited range of therapeutic agents.
Purpose of the study. To improve the results of treatment of patients with cicatricial obliteration of the urethra.
Material and methods: The basis of the work was an analysis of the treatment results of 53 patients with urethral obliteration who had a complete physical examination, endoscopic treatment and further observation in Republican Specialized Scientific and Practical Medical Center of Urology. The age of patients ranged from 13 to 80 years (average 46.4 ± 19.8 years). When contacting the clinic, all patients had suprapubic cystostomy drainage, which was previously installed due to the inability to urinate independently. Criteria for inclusion in the study was: availability of cicatricial obliteration of the urethra and neck of the bladder; high operational risk due to concomitant diseases; averseness of risk of sexual dysfunction; recurrence of cicatricial obliteration after unsuccessful reconstructive plastic surgery. Criteria for exclusion was: presence of urethro-perineal urinary fistulas; significant deviation of the meatus and displacement of the ends of the urethra. To restore patency of the obliterated urethra, we developed a new method for endoscopic treatment of urethral obliteration, which consists in determining the location and length of the urethral obliteration, creating of primary urethral canal under control of polypositional x-ray telecriteriascopy and electroresection of scar tissue. Effectiveness of the endoscopic urethral recanalization was evaluated according to the frequency of recurrence of urethral stricture at 1, 6 and 12 months of observation, regardless of the location and extent of obliteration.
Results: The average duration of the operation was 36.3 ± 2.5 minutes. The need for drainage of the bladder after surgery averaged 23.1 ± 1.2 days (range 21–29 days). The average patient stay in hospital (bed-days) was 6.1 ± 2.7 days (range 1–16 days). Among the most serious intraoperative complications, bleeding was observed, which was observed in 1 patient (1.9%). Among the postoperative complications, the most frequent were infectious and inflammatory complications – in 7 (13.2%) patients. Of these, 6 patients had urethritis, 1 patient had acute prostatitis. In the process of observation, the number of relapses steadily increased, reaching 18.9% by the end of the study.
Conclusion: Endoscopic urethral recanalization is an available and effective method in treatment of patients with urethral obliteration. Relapses after this type of intervention by the end of 1 year of observation occur in 18.9% of patients.

GUA-25 Laparoscopic radical prostatectomy for locally advanced prostate cancer: a retrospective study

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Background: Patients with locally advanced prostate cancer (PCa), defined as a clinical tumor category ≥cT3, are at greater risk for subsequent disease-specific mortality. Currently, there is no consensus regarding the optimal treatment of men with locally advanced PCa and the data concerning minimally invasive surgical options in this category are scarce. In the present study, we aimed at reporting our experience with laparoscopic radical prostatectomy (LRP) and extended pelvic lymph node dissection (ePLND) in patients with cT3 or higher stage PCa treated at two centers in Georgia.
Methods: A total of 138 patients with locally advanced PCa, defined as cT3 or higher stage on digital rectal examination and/or magnetic resonance imaging, were retrospectively identified. Patients underwent LRP and ePLND from 2010 to 2016. Perioperative outcomes analyzed were operative time, blood loss, length of hospital stay, and complications occurred within 30 days after surgery. Oncological outcomes and the need for adjuvant therapy were also recorded.
Results: The median age at surgery was 65 years. The median prostate-specific antigen at diagnosis was 15.03 ng/mL. Median operative time, blood loss, and length of hospital stay were 180 minutes, 200 mL, and 6 days. Pathological stage pT2 was reported in 28 (20.3%), pT3a in 62 (44.9%), pT3b in 44 (31.9%), and pT4 in 4 (2.9%) cases. The median number of lymph nodes removed was 18. Overall, 48 (34.8%) and 31 (22.5%) patients had positive lymph nodes and positive surgical margins, respectively. In total, 23 (16.7%) patients experienced complications, classified as Clavien category I in 8 (5.8%), Clavien II in 6 (4.4%), Clavien IV in 2 (1.4%), and Clavien V in 1 (0.7%) patients. The latter outcome was not related to the surgery or cancer-specific causes. Overall, 42 (30.4%), 49 (35.5%), 13 (9.4%), and 16 (11.6%) patients received adjuvant radiotherapy (RT), hormonal therapy (HT), salvage RT, and salvage HT. Median follow-up after surgery was 21.5 months. The one-year urinary continence recovery rate was 72%. At 3-year follow-up, biochemical recurrence-free and clinical recurrence-free rates were 70.6% and 93.3%, respectively. Limitations of our study were its retrospective nature and short duration of follow-up.
Conclusions: LRP is a safe and effective option in patients with locally advanced PCa either alone or as a first step in a multimodal setting. Further studies with longer follow-up are needed. Individual predictors of biochemical recurrence should also be identified to better select patients for multimodal treatment.

GUA-26 Does TESA as effective as micro-TESE during nonobstructive azoospermia or embryologist factor is most important?

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Introduction and objective: Azoospermia is the absence of spermatozoa in ejaculate even after semen centrifugation at least two times. Azoospermia due to spermatogenic fauilure – nonobsobstructive azoospermia (NOA) observed in 1% of population and in 10–15% of infertile men. Predictive factors for the presence of spermatozoa in testis are still under debate.