

After 6 months of follow up according to 1-hour pad test only in 2 cases leakage were >10 g. Postoperative urinary retention was only in 1 case and was managed by tape “pull down” with Gagar dilatator in urethra (in 24 hours after operation) with good final results. Vaginal extrusion of sling was found in 1 case after 1 month of operation (wound area). Wound was closed successfully without tape cutting or removal. Functional Results Qave 18.9 ml/s (range 11.6–22.9 ml/s), no post void residual.

**Conclusions:** When surgical revision of MUS is undertaken, there is no clear evidence to favor either incision or excision with regard to relief of VD, or the risk of de-novo SUI recurrence. Professional experience and patient’s clinical status should guide decisions. Our series of this complicated cases show that “salvage” sling after obstructive sling cutting had good functional results. We try to show that so-called “salvage” sling can avoid re-operation (third operation in mid-urethra part) for de-novo SUI after obstructive sling cutting.

### GUA-30 Skene’s gland duct cysts: our experience

Aleksander Khelaia, Nino Turmanidze  
National Center of Urology, Tbilisi, Georgia

**Introduction and Objective:** Skene’s glands or periurethral glands are branched, tubular glands that are adjacent to the distal urethra. Skene’s glands are the largest of the paraurethral glands, however many smaller glands empty into the urethra. Most cases are acquired as a result from repeated infections and obstruction of the periurethral glands. Ductal obstruction leads to formation of suburethral cysts or abscesses that may rupture into urethral lumen and lead to urethral diverticulum formation.

**Material and methods:** In our study we included 32 cases operated in our center from 2010 year. Clinical presentations were presented with multiple symptoms: palpable or visible mass at the introitus, pain, dyspareunia, dysuria, a distorted voiding stream and a vaginal discharge. It should be mentioned that periurethral cysts may be totally asymptomatic and discovered during routine pelvic examination. Palpation of this mass may result in a purulent discharge from the external urethral meatus but this “classic” sign was only present in 30% of cases. Transvaginal ultrasound/translabial ultrasound has excellent sensitivity and anatomic delineation and was useful for investigation. The size (in our series up to 4 cm), number, location, structure, content and wall thickness may be obtained but the disadvantage that the probe may directly compress the urethra, so translabial approach was option.

**Results:** All 32 cases were operated, we didn’t perform as so called marsupialisation (an incision through the cyst/diverticulum to its urethral orifice). So, we prefer complete excision of cyst. In lithotomy position, an inverted U shape incision of well vascularised anterior vaginal wall, flap was mobilized towards the bladder neck. In cases of “paramental” lesions longitudinal incision was done. Complete excision of the cyst wall should be done. In the presence of urethral diverticulum neck (40% of cases in our series, which half were detected during operation), resultant large urethral defect should be repaired in a multi-layered non-overlapping closure with absorbable sutures. Only in one case with urethral orifice diameter about 1.5 cm was done tissue interposition with the Martius graft from left labia. In cases with urethral reconstruction Foley’s catheter was left for 7–10 days, in other cases for 48 hours. No major complications in post-operative follow up.

**Conclusions:** The diagnosis of female periurethral cystic lesions is challenging for clinicians because patients present with nonspecific signs and symptoms. Sometimes final diagnosis was done at the time of operation; we think it is mandatory to avoid missing of cystic lesions connection with urethral lumen.

### GUA-31 Peculiarities of operative intervention at stones of the distal ureter

D. B. Tulaganov, B. M. Ismatov, G. U. Ubaidullaev, Sh. O. Tuychiev, Y. S. Nadjimitdinov  
Jizzakh Branch of the Republican Scientific Center for Emergency Medicine, Uzbekistan

**Background:** Often, calculi of the ureter are located in its terminal section and are the cause of significant dilatation of the urinary tract. However, the presence of a stone in the lumen of the ureter for a long time leads to a pathological change in the ureter wall and inflammation (with subsequent formation of gross scars) in the surrounding tissues. Such a condition requires not only stone removal, but also reconstructive surgery of the ureterovesical joint. We have retrospectively reviewed of the results of surgical treatment of patients with stones located in the distal ureter was performed, depending on the duration of the disease.

**Methods:** For the period from January 2010 to December 2018, surgical intervention was examined and performed for calculi of the distal ureter in 87 patients. The average age of the patients was  $34.7 \pm 9.5$  years (18 to 56 years). There were 65 men (74%), 22 women (26%). All patients underwent: urinalysis (bacteriological examination of urine was performed in the presence of bacteriuria), biochemical and clinical blood tests; urinary tract ultrasonography. To determine the size and location of the stone, an overview and intravenous excretory urography was performed (in order to determine the functional state of the kidneys). The average stone size was  $2.3 \pm 0.4$  cm. The calculi in the left ureter were 78 (89%), and in the right ureter 9 (11%).

**Results:** All patients had access to the ureter using a suprapubic incision according to Pfanenstil, suggesting the likelihood of reconstructive surgery on the ureter. Ureterolithotomy was performed through an incision of the ureter wall performed proximal to the location of the stone in 76 (87%) patients. It should be noted that the duration of the disease in this group of patients averaged  $6.4 \pm 0.3$  months. During the audit of the ureter in 11 (13%) cases, it turned out that its wall was significantly thickened and densified, there was a significant scar process in the tissues surrounding it. After stone removal during revision, a narrowing of the intramural ureter and ureterovesical anastomosis was revealed, while a 4 Ch catheter could not be passed through their lumen. These patients underwent neointplantation of the ureter into the bladder with antireflux protection according to Politano-Leadbetter. Ureteric stent was used to decompress the upper urinary tract. The duration of the disease in this group of patients averaged  $12.4 \pm 0.3$  months.

**Conclusions:** Prolonged presence of a stone in the distal ureter can lead to fibrous in the ureterovesical connection, which is the cause of suprapubic obstruction. When planning ureterolithotomy in patients with calculi of the distal ureter, it is advisable to use online access to perform not only stone removal, but also, if necessary, reconstructive surgery to restore the passage of urine.

### GUA-32 Laparoscopic en bloc extended pelvic lymph node dissection in prostate cancer

David Nikoleishvili<sup>1</sup>, Givi Koberidze<sup>1</sup>, Zaza Tchanturaia<sup>2</sup>, Ambrosi Pertia<sup>2</sup>  
<sup>1</sup>MediClubGeorgia Clinic, Tbilisi, Georgia; <sup>2</sup>National Center of Urology, Tbilisi, Georgia

**Background:** Extended pelvic lymph node dissection (ePLND) is indicated in patients with intermediate- and high-risk prostate cancer.