(25.4%) – 7–10. Frequency and nature of postoperative complications were assessed by Clavien-Dindo classification, preoperative urinary tract infection (UTI), CCI score and method of urinary diversion.
Results: Patient distribution with IIC in accordance with the Clavien-Dindo classification is presented in Table 1.

Table 1

Complications	Grade I	Grade II	Grade				Grade V
			IIIa	IIIb	IVa	IVb	
Surgical site infection (SSI)	–	7(3.16%)	–	–	–	–	–
Abscess	–	–	2(0.9%)	–	–	–	–
UTI	–	23(10.4%)	–	–	2(0.9%)	1(0.45%)	–
Acute Coronary Insufficiency	–	–	–	–	–	–	2(0.9%)
Pulmonary Thromboembolism	–	–	–	–	–	–	6(2.71%)
Multiple Organ Failure (MOF)	–	–	–	–	–	–	8(3.62%)

Mortality rate in the early postoperative period (30 days) was 7.2% with IC being the main cause. SSI was observed in 7 cases. Two patients had abdominal and pelvic abscesses, which were drained using local anesthesia. UTI was diagnosed in 26 cases. In 3 cases the infection resulted in sepsis.
Analysis of IC ethiology in the early postoperative period revealed correlation between CCI score and the incidence of SSI and abdominal abscesses. The causal factors for the development and exacerbation of UTI in the early postoperative period included prior invasive urinary tract procedures and method of urinary diversion.
Conclusion: High CCI score (7–10) is one of the predictors of IC in the early postoperative period. Urinary diversion method also contributes to the UTI development. Intestinal reconstruction is acceptable in patients with low CCI score, because the incidence of IC is insignificant. Urine bacterial analysis in patients undergoing invasive procedures should be the integral part of preoperative period. The choice of antibacterial drug is carried out in accordance to microbiological results. This procedural complex reduces the incidence of UTI in the early postoperative period.

GUA-49 Holmium laser enucleation of the prostate: overview of our results after the first 14 months of acquisition

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Background: Benign prostatic hyperplasia (BPH) is one of the common diseases among older men, which in most cases causes infravesical obstruction and the development of lower urinary tract symptoms. According to the European Association of Urology, as well as the MEDLINE database, the prevalence of BPH is 60% among men aged 60 years and 80% among patients 80 years and older.
In the last decade, the treatment options for BPH patients have significantly expanded. Although, transurethral resection (TUR) of BPH is still considered the main standard of surgical intervention. As an alternative (TUR) of BPH have been introduced various methods, but laser technologies remain relevant especially for large volumes of BPH.
Methods and materials: Since July 2018, in our center, 93 patients have had surgery with using laser e.i., HOLEP with BPH. The volume was from 60 ml to 145 ml. Four patients interoperatively had only mucosal bladder damage without perforation of the wall itself. Postoperative complications such as hematuria were in 7 patients. For three of them required coagulation of the bleeding area of the BPH's capsule. In 2 patients was formed postoperative sclerosis of the bladder neck. The result of IPSS, QoL quality of life assessment and urodynamic data were compared before and after surgery.
Results: The international prostate symptom score (IPSS), residual urine volume and urination time (VT) decreased significantly, and the maximum urine flow rate (Qmax), average urine flow rate (Qave) and quality of life assessment (QoL) significantly increased in the postoperative period.
Thus, an analysis of the survey results based on the IPSS scale showed a significant decrease in the total score after surgery. Before surgery, the total score was from 9 to 33, and after surgery from 0 to 8 ($p < 0.0001$). The results of quality of life assessment associated with lower urinary tract symptoms before surgery ranged from 2 to 6 points, after surgery from 0 to 4, which indicates a significant increase in quality of life ($p < 0.0001$). The maximum urination rate before surgery was 7 ± 2 ml/sec, after the operation it significantly increased to 20 ± 7 ml/sec. There was also a significant increase in the average rate of urination, which was 4 ± 2 ml/sec before surgery and 12 ± 4 ml/sec after surgery.
As for the intra and postoperative complications and features during this period, the acquisition of experience to draw certain conclusions is considered premature. Nevertheless, our little experience shows that we fit into the data of international statistics.
Conclusions: Our results illustrate that HOLEP is an effective procedure of treatment for moderate to high volume BPH.

GUA-50 Our experience of treating intraurethral prostatic cysts by transurethral resection

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Background: Prostate cyst is a fairly rare disease and accounts for about 8–10% of cases. Detection of prostate cysts is mostly an accidental finding in urological practice. The reasons for the treatment of patients are symptoms such as: obstruction, dysuria, chronic pelvic pain, haemospermia, a feeling of incomplete bladder emptying, infertility, painful ejaculation, acute urinary retention and urinary tract infection.
Objective: The study of clinical diagnostic criteria and the finding of operational tactics in patients with prostate cysts.
Materials and methods: For the period from 2013 to 2018, in our clinic, prostatic cysts were diagnosed and subsequently underwent surgical treatment – 13 men aged 21 to 57 years who complained of difficulty in urinating (9 patients), feeling of incomplete bladder emptying (3 patients), chronic pelvic pain (1 patient). All patients underwent ultrasonography, transrectal ultrasonography TRUS, uroflowmetry, urethrocystoscopy and CT/MRI, according to which other urinary tract anomalies were not detected.
Results: Cysts were found from 2.0 to 4.7 cm in diameter, which were in the proximal prostatic urethra. Uroflowmetry data of patients showed obstruction with the following parameters: t – 53.1 ± 3.2 sec, Qmax – 9.1 ± 1.3 ml/s, Qmid – 6.2 ± 1.3 m/s, V – 224.4 ± 16.1 ml, R – 39.3 ml. The patient underwent transurethral electroresection of the cystic cavity with excision of the edges with taking tissue for a biopsy e.i. transurethral resection of the cyst with limited resection of the anterior prostatic tissue at the base of the cyst was performed. After resection the straw-colored liquid is exuded at opening the cavity of the cyst. A straw-colored liquid released after cyst resection at the opening of its cavity. Dynamic observations showed subjective improvement, disappearance of previous complaints. The data of urofloomery is significantly improved: t – 27.1 ± 3.2 sec, Qmax – 19.4 ± 1.3 ml/s, Qmid – 12.7 ± 1.3 ml/s, V – 231.3 ± 16, 2 ml, R – 12.4 ± 3.1 ml.

Conclusions: Prostatic cysts are a rare disease that can cause obstruction of the lower urinary tract. In this regard, when identifying large-sized prostate cysts with obstructive symptoms, the optimal treatment method is transurethral resection, i.e., deroofing.

GUA-51 Overview of our results about treatment of a complicated urinary tract infection as a calcinated biofilms on the surface of bladder mucous

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Background: Urinary tract infection (UTI) is one of the most common diseases in urological practice. In the USA, UTI is the reason for admission to the hospital of more than 7 million patients yearly; in many cases, the most common reasons for hospitalizations is ineffective outpatient treatment of a large group of patients. A special category of UTI is complicated infections.
The cause of UTI complications often, besides foreign body, stones and abnormalities of the urinary tract is also catheters. Treatment of complicated UTI is sometimes long and ineffective.
Our experience shows that similarly to catheter-associated infections, often infected calcified biofilms are formed on the surface of bladder mucosa, which eventually becomes intimately knitted to the submucosa, and sometimes to muscle wall of the bladder. In the history, as a rule, such patients had a prolonged catheterization of the bladder.
Materials and methods: Since 2010 to 2018, 32 patients with calcified biofilms on the surface of bladder mucosa were diagnosed in our clinic. Patients complained of dysuria, pain in the urogenital area, hematuria, and the ineffectiveness of antibiotic therapy. According to bacteriological urine culture, *E. Coli*, *Klebsiella* spp., *Pseudomonas* spp., *Proteus* spp., as well as mixed flora were identified as the most common disease-producing factors.
Diagnosis of infected calcified calcified biofilms on the surface of bladder mucosa was based on anamnesis, urinalysis, urinary tract ultrasound, CT, and urethrocystoscopy. The age of patients was 42–73 years. The area of the infected calcified biofilms on bladder mucosa ranged from 1.0–5.2 cm, visually resembling an infected soft calculus of light yellow color, which was intimately knitted to the submucous layer of the urinary bladder.
Results: All these patients underwent transurethral electroresection of the infected calcified biofilms on the surface of the bladder mucosa with a biopsy. 12 patients have recurrence of this disease repeatedly, for 8 of them was decided to divert urine by insertion of suprapubic cystostomy. After transurethral electroresection of the infected calcified biofilms on the surface of bladder mucosa, this group of patients for a long time underwent installation with antiseptic solution "Cyteal," synthomycin emulsion and sea buckthorn oil through the cystostomy tube.
Further, we did not noticed recurrence in this group of patients. However, 3 patients, even after suprapubic cystostomy and conservative therapy had recurrence of the disease. These patients underwent percutaneous nephrostomy and subsequently transurethral electroresection and long-term conservative therapy (installation with antiseptic solution into the bladder). Only after these measures the recurrence of the disease did not occur. Drainage removal was performed on average 35 days after surgery. Biopsy results of all 32 patients showed the presence of an inflammatory-infiltrative and scar-sclerotic process.
Conclusions: The obtained data indicated that this is a rather complex category of patients requiring transurethral resection of the infected calcified biofilms from the bladder mucosa, often repeatedly, in some cases with urine diversion. After the surgery procedure in the dynamics of the disease with antibacterial and anti-inflammatory therapy, all patients subjectively noted improvement and objective data improved according to urinalysis, ultrasound, urethrocystoscopy and CT.

GUA-52 Results of application of radio-frequency ablation in treatment of malignant and beneficial new formations of parchimatous organs and bones

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Background: Radio-frequency ablation (RFA) can be performed by open access, with video laparoscopy, or transdermal under the supervision of ultrasound or computed tomography. RFA – an effective method that has improved the results of loco regional treatment of patients with tumors of parenchymal organs, has now taken a leading place among surgical treatment methods in oncology and hepatology.
Objective: To show the possibilities and experience of using minimally invasive intervention – radio frequency ablation in the treatment of malignant neoplasms of the liver, kidneys, bones and lungs.
Materials and methods: From November 2015 to October 2016 "National Research Oncology Center" underwent treatment using RFA for 15 patients. Using computer navigation for focal changes in the lungs and bones, 3 (20%) cases were performed, as well as with ultrasonic navigation, in 12 (80%) patients, of which 2 (16%) cases were RFA of liver metastases, 2 (16%) patients – with kidney tumors, one patient underwent RFA of intraparenchymal liver metastasis from laparotomy access during radical surgery for kidney cancer. The average age of the patients was 58 ± 7.3 years for the RF of the liver and 17 ± 6.0 for the RF of the lungs, bones and kidneys. The diameter of the neoplasms varied from 2.0 to 5.7 cm, the number of tumor nodes did not exceed 3. All neoplasms were verified after a puncture biopsy with ultrasound navigation. In some cases, a biopsy was performed in one session of analgesia, along with RFA. All influences were performed in the operating room, two patients underwent local anesthesia, and the rest received intravenous anesthesia. For RFA, the technique was used with a single or cluster needle tip "Cool-Tip" 15–25 cm long with a working part of 1.0–3.0 cm or a combination of several electrodes (up to three) in the presence of several neoplasms in one parenchymal organ. The duration of the procedure was determined individually. The criterion for completing the procedure was the formation of a hyperechoic zone of induced changes comparable with the size of the tumor according to intraoperative ultrasound. When the tumor size exceeds the length of the working part of the electrode, a sequential effect was made from several points using the technique of "overlapping spheres." The duration of the RFA procedure was from 10 to 30 minutes (15 ± 2.2 minutes). Percutaneous access under the control of ultrasound is used in most patients. RFA of intraparenchymal metastasis of the liver was performed once from laparotomy access during radical surgery for kidney cancer. The electrode was carried out, avoiding the coincidence of the injection path with large intrahepatic vascular structures. For tumor sizes greater than 30 mm, RFA was performed from several points of exposure, with the most distant pole of formation being punctured initially, followed by extraction of the electrode into the surface of the tumor. The operation was completed by coagulation of the puncture channel in order to prevent implantation metastasis and achieve hemostasis. To avoid the risk of damage to neighboring organs, in 2 cases, before the RFA of the liver, a liquid layer ("airbag") was created in the contact zone by puncture injection of a solution of 0.5% glucose under ultrasound control. The local effect was evaluated using various monitoring techniques: