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: