

ultrasound, spiral computed tomography with intravenous contrast (CT), MRI, puncture biopsy of the tumor under the control of ultrasound.

Results: In the early stages after the operation, standard side effects associated with access were observed: pain at the site of the puncture or surgical wound, subfebrile condition. With the destruction of liver tumors with a diameter of more than 3 cm, a transient increase in transaminases and bilirubin, alkaline phosphatase was observed. Postoperative mortality was not observed. Ultrasound in the early stages after the operation determined the formation of different echogenicity of a slightly larger diameter than the primary focus, which corresponded to the size of the destruction zone. Subsequently, these formations decreased slightly. In some cases, small tumors subjected to RFA were not visualized by repeated ultrasound. CT revealed homogeneous formations in the area of tumor destruction that did not accumulate a contrast agent in renal tumors. The presence of contrast perfusion after RFA of parenchymal organs made it possible to suspect incomplete tumor destruction.

GUA-53 The role of minimally invasive treatment methods in patients with neoplasms of the bladder with macrohematuria

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Background: With prolonged and severe hematuria from the lower urinary tract, urological surgeons have to ligate the internal iliac arteries by the open method, under general anesthesia, while a number of patients have somatic diseases, weakened and a high operational risk. Minimally invasive surgery – chemoembolization for bladder cancer can be an alternative to the complex treatment of this formidable disease.

Material and methods: In the “National Research Oncology Center” from 2016 to November 2018, 12 patients with bladder cancer underwent “Chemoembolization of the Lower Cystic Arteries” The chemotherapy drug for this procedure was adriamycin in a dosage of 50 mg or cisplatin 50 mg. Hemosphaerae loaded microspheres 300–500 µm in size from Biosphere Medical (France) were used as a source of transportation of the chemotherapy drug. Seven out of 12 patients had stage T2N0M0 RMP, two stage T3NxM0 and 4 patients T1N0M0, all of them histologically verified transitional cell carcinoma G2-3.3 of them had an expansion of the upper urinary tract on one side and 1 on both sides. Ten patients reported episodic bleeding in the form of blood clots in the urine, while two had total macrohematuria. Embolization of the cystic arteries was performed under local anesthesia by transfemoral access according to Seldinger under radiological control. Patients were discharged on the third day after surgery. All 12 bladder cancer patients underwent two «Chemoembolization of the Lower Cystic Arteries» courses with an interval of one month.

Results: The treatment results were evaluated according to the general condition of the patients, complaints, lack of hematuria, a decrease in the size of the tumor, and positive dynamics of the blood test parameters. In the first 2 days, 3 patients had a pain syndrome that passed after the use of non-narcotic analgesics. Hyperthermia, local pathological changes in the area of the introduction of a vascular catheter into the femoral artery were not observed. After two months during the follow-up examination, the patients did not have episodes of macrohematuria, blood tests improved. According to CT, ultrasound, cystoscopy, tumor sizes decreased on average by more than 25% after 2 Chemoembolization of the Lower Cystic Arteries. Six patients three months after the first Chemoembolization of the Lower Cystic Arteries underwent surgical interventions in the amount of transurethral resection – 4, open resection – 1, cystectomy – 1. The histology of the

removed tumor confirmed the therapeutic necrosis of the tumor tissue. Three patients with a common disease were referred for further chemoradiotherapy and three with an initial stage of the process continue to be followed up with the recommendation of local chemotherapy.

Conclusion: Thus, Chemoembolization of the Lower Cystic Arteries is a minimally invasive but effective method of exposure to bleeding from the bladder. It needs widespread use among patients when concomitant diseases do not allow the implementation of volumetric routine treatment methods. The small number of patients and the short follow-up period do not give grounds for final conclusions on the duration of treatment and the number of Chemoembolization of the Lower Cystic Arteries sessions in patients with bladder cancer.

GUA-54 X-ray vascular treatment of prostate cancer

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Background: Prostate cancer is the leading disease worldwide. In the treatment of this disease, there are many moments when the use of routine treatments is not possible due to a number of objective reasons, such as age and other concomitant diseases, often make it impossible to carry out surgical methods. Especially in hormone-refractory form of prostate cancer, when cancer cells are insensitive to antiandrogenicity.

Minimally invasive surgery – chemoembolization in prostate cancer can improve the results of treatment in combination with conventional methods of treatment.

Prostatic artery embolization was first applied F. Carnevale, São Paulo, Brazil, (2009).

Materials and methods: In 2016, in a National Research Oncology Center, four patients with prostate cancer underwent “Super-selective chemoembolization of the prostatic arteries”. The chemotherapy drug for this procedure was adriamycin in a dosage of 50 mg. Hepasphere microspheres 300–500 microns in size from Biosphere Medical (France) were used as a source of transportation of the chemotherapy drug. Two out of four patients with prostate cancer had a hormone-resistant form. Three patients had stage T3bN0M0 prostate cancer, one stage T2bN0M0, histologically verified, Gleason number 7, 7, 8, 9. All patients had difficulty urinating, the amount of residual urine was from 54 to 98 ml. One of them, according to ultrasound sonography, had a pronounced expansion of the upper urinary tract. According to TRUS, the average volume of the prostate gland was 63 mm³. The average PSA level was 17 ng/ml. Super-selective chemoembolization of the prostatic arteries was performed under local anesthesia by transfemoral access according to Seldinger under radiological control. Patients were discharged on the third day after surgery. All were examined one month after Super-selective chemoembolization of the prostatic arteries. The treatment results were evaluated by their general condition, complaints, assessment of lower urinary tract symptoms according to the IPSS scale, reduction of prostate volume and a decrease in the amount of residual urine, and PSA level in dynamics. In the first 7 days, 3 patients had a pain syndrome that passed after the use of non-narcotic analgesics. In blood tests, hyperthermia, local pathological changes in the area of introduction of a vascular catheter into the femoral artery were not observed. After one month, a follow-up examination in all patients with obstructive symptoms showed an improvement in urination. In a patient with 2-sided expansion of the upper urinary tract, a significant decrease was noted. In all 4 patients, the amount of residual urine did not exceed an average of 50 mm³. According to the control TRUS, the prostate volume decreased to 38 mm³. The average PSA level was 8.0 ng/ml. IPSS before surgery = 25, L-5. In dynamics, a month after the operation, the IPSS gradient was 37.4 ± 3.6%. Thus, Super-selective chemoembolization as

a minimally invasive but effective method of exposure in prostate cancer. Especially in need of widespread use among patients when concomitant diseases do not allow radical routine operations and antiandrogen therapy of hormone-refractory prostate cancer.

Summary: A small number of patients and a short period of follow-up do not give grounds for final conclusions in the duration of treatment and the number of sessions of Super-selective chemoembolization of the prostatic for each patient with prostate cancer.

GUA-55 The quality of life in renal transplant recipients and dialysis patients

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Abstract: Health-related quality of life (HRQoL) is becoming an important outcome measure in evaluation of various forms of renal replacement therapy (RRT). The Short Form-36 (SF-36), Giessen Subjective Complaints List (GGB-24), and Zerssen's Mood Scale (Bf-S) are internationally validated questionnaires for the assessment of HRQoL. The goal of the current study was to evaluate the HRQoL of renal transplant recipients and compare it with that of patients on different forms of RRT. The study population consisted of: (1) 120 patients on hemodialysis (HD); (2) 43 patients on peritoneal dialysis (PD); (3) nine recipients who lost their grafts and went back to dialysis; (4) 120 age- and sex-matched healthy individuals (controls); and (5) 48 renal transplant recipients. The mean SF-36 scores were not significantly different between control group and transplant recipients as well as HD and PD patients including previously transplanted patients. The dialysis patients scored significantly worse in all eight SF-36 domains compared with transplant recipients and healthy subjects. In all GBB-24 components, the transplant recipients scored significantly higher than HD and PD patients. In the "fatigue tendency," "limb pain," and "cardiac complaints" components, recipients scored significantly higher than control group subjects. The mood analysis (Bf-S) showed that the scores of transplant recipients and controls did not differ, being significantly higher than those of dialysis patients. The HRQoL of patients on HD and PD were similar and lower than that of the general population. Renal transplantation significantly improved HRQoL at least to the level of healthy individuals. Graft loss was associated with significant worsening of HRQoL.

GUA-56 Tubeless mini PCNL with antegrade stent tether in preschool children

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Background: According to the European Association of Urology guidelines, PCNL is recommended as primary treatment option for large renal stones (>20 mm) and also for >10 mm stones of the lower renal pole. Miniaturization of instruments, particularly smaller nephroscopes and the potential to use lasers will decrease the morbidity and improve the clearance rates. The need of postoperative cystoscopy for ureteral stent removal one of the limitations of Tubeless miniPCNL in children, which needs use of narcotics, postoperative urination discomfort, sometimes hospital stay for children.

Objective: The present study was designed to evaluate the safety and efficacy of Mini-PCNL with antegrade stent tether in preschool children.

Material and Methods: From August 2018 to August 2019, in our medical center, 52 infant patients underwent tubeless mini-PCNL

with antegrade stent tether. All procedures performed by Storz MIP system 12F nephroscope, using 16F metallic sheath. Stone fragmentation was performed holmium laser and pneumatic lithotripter. All cases were finished with antegrade stent placement with proximal tether via percutaneous tract, which protected by a clear occlusive bandage. The prolen thread was sutured through the proximal lumen of stent and from inside to outside which contributed to the easy removal while minimizing damage to surrounding tissue with the tip of the stent.

Results: A total of 52 children – (42 male, 10 female), with a mean age 54.5 (17–75) months were included in this study. The mean size of the stones was 19.0 (15–24) mm. Renal stones were located in renal pelvis (n=34), lower pole (n=11), middle pole/upper pole (n=7). All intrarenal access was performed in the prone position under ultrasound and fluoroscopic guidance. Stone free rate was 98%. Mean operative time was 68.5 (45–92) min. Hospital stay time was 2–3 days in all cases. In all cases ureteral stent removed by tether via flank without anesthesia, in 40 (76%) cases in third day and in 12 (24%) cases in fifth day after surgery. There was no incidence of bleeding and pain during stent removal.

Conclusions: Tubeless mini PCNL with stent tether is safe and effective technique for preschool children which avoids possibility of post-operative cystoscopy, anesthesia, hospital stay and allows easy access to calyceal system for second look via nephroscopy when necessary.

GUA-57 Transurethral enucleation of prostate by one-step en-bloc technique

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Background: According to the recent EAU Guidelines on Treatment of Non-neurogenic Male LUTS (2019), caused by benign prostatic hyperplasia (BPH), transurethral resection remains a "gold standard" for endoscopic treatment of BPH up to 80 cc. In case of greater BPH glands are recommended open prostatectomy or minimally invasive so-called Endoscopic Enucleation of the Prostate (EEP). All methods such as HoLEP (holmium laser enucleation of the prostate), ThuLEP (thulium laser enucleation of the prostate), electro enucleation (mono- or bipolar) have proved their efficacy and safety. Basically, EEP applies lobe by lobe enucleation technique. Recently, to improve outcomes and to decrease learning curve of surgeons, are presented novel en bloc technique of prostate enucleation.

Objective: The aim of the study was to evaluate the applicability of a novel en bloc enucleation technique in patients with lower urinary tract symptoms (LUTS) caused by BPH.

Material and methods: Between August 2018 and April 2019, 63 enrolled patients with diagnosed BPH underwent one-step en bloc enucleation of prostate by using enucleating bipolar electrode (Karl Storz). All interventions are performed by an experienced urologist. In contrast to traditional lobe by lobe enucleation technique, all lobes were enucleated in one step. First it starts from verumontanum position at 5 and 7 o'clock to identify the plane between surgical capsula and BPH. Using the beak of the resectoscope and bipolar energy, by further circular and forward moving motions the plane was developed until the bladder neck. After the enucleation, all lobes en bloc moved into the bladder and were morcellated under direct vision. Surgery was finished by inserting 3-way 20F Foley catheter with continuous irrigation.

Results: The surgery was technically successful in all patients. The prostate volume was from 60 to 250 cc; total enucleation time were 42.8 to 55 min respectively, total removed prostate weight was from 62 cc to 250 cc. Blood loss during surgery was from 54 to 85 ml. Urethral catheter was routinely removed in 48 hours after surgery, in 2 cases after 5 days without residual urine. Hospital stay was 2 to 4 days.