

SLEEVE VERSUS FORCEPS GUIDED TECHNIQUE FOR MASS CIRCUMCISION EFFORTS FOR HIV PREVENTION

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(Presentation to be made by Dr. Gudeman)

Introduction and Objectives: Many African countries suffer high HIV rates, which can be curbed by circumcision. As a result, mass circumcision projects have emerged, with different techniques being employed. Forceps guided (FG) technique is more efficient and yields higher volume in mass circumcision efforts, though cosmetic results may be compromised. Western urologists tend to be more familiar with the sleeve technique (SL) and carry that experience with them when they volunteer. Surgeons are expected to perform from 25-40 circumcisions in a day, so efficiency is vital. The aim of this study was to determine whether surgeons comfortable with sleeve technique should adopt FG technique. Are they faster with the SL as a result of their experience?

Materials and Methods: A single U.S. trained urologist, primarily trained to perform SL technique, travelled to Swaziland, Africa in support of a mass circumcision effort. He performed over 400 circumcisions; having rapidly adopted FG technique with minimal training. All circumcisions were performed using the previously described MOVE model, in which 4 stations were set up per surgeon, and a suture nurse completed closure after placement of initial quadrant sutures. After becoming familiar with the team, careful timing of 41 FG and 21 SL circumcisions was carried out. Time from incision to hemostasis was recorded.

Results: Mean times were 3.58 minutes versus 6.93 minutes for 41 FG versus 21 SL circumcisions ($p < .0001$; unpaired t-test), with difference in time of 3.4 minutes. There was, subjectively, more bleeding in nearly all SL cases. In the interest of time, The SL technique was abandoned as there were many patients who would not have been able to be circumcised on the day of the study.

Conclusion: The FG technique for circumcision is a faster, more efficient technique in mass circumcision efforts. This is true even for surgeons who are primarily adept with the SL technique, as the technique can be readily adopted. Depending on the surgical volume of the program, performing SL technique can add from 90 to 150 minutes to a day, with the possibility of patients being turned away. More work is needed regarding cosmesis and long term follow-up.

MALIGNANT PRIAPIISM AS A PRESENTING SYMPTOM OF METASTATIC BLADDER CANCER

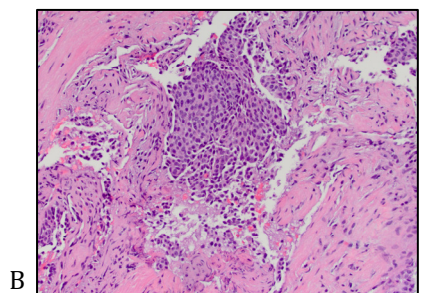
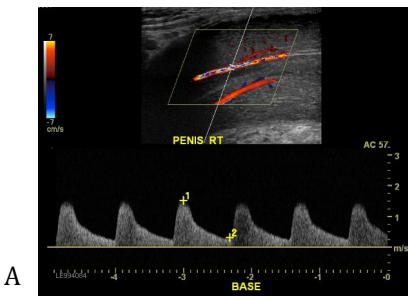
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(Presentation to be made by Dr. Smith)

Purpose: Priapism secondary to penile metastasis is extremely rare. The primary tumor is often genitourinary, usually arising from the bladder or prostate. We present a case of priapism as the presenting symptom of metastatic transitional cell carcinoma of the bladder.

Methods: The patient is a 69 year-old male who was diagnosed with muscle-invasive transitional cell carcinoma of the bladder 6 months prior to presentation. He declined surgery and bladder-sparing therapy. He had new onset erectile dysfunction with inability to achieve erections 2-1/2 months ago. Subsequently, he developed a rigid erection that persisted for two months. Pain was controlled with oral analgesics. On exam, he had corporal rigidity with a soft glans and no palpable abnormalities. An MRI of the abdomen and pelvis, including the penis, showed no evidence of metastasis. Penile duplex ultrasound showed single corporal arteries bilaterally with normal diameter and flow, and no corporal abnormalities. Aspiration was precluded by minimal blood return. Tru-Cut biopsies were performed under anesthesia, taking 2 cores from each corpora proximally and distally for a total of eight cores. There was minimal bleeding from the biopsy sites.

Results: Final pathology from all Tru-Cut biopsy cores revealed invasive carcinoma consistent with high-grade urothelial carcinoma. Lymphovascular invasion was identified in all cores.

Conclusions: Metastatic urothelial carcinoma to the penis can present as persistent priapism with a negative metastatic work-up. Penile biopsy may be needed to confirm diagnosis.



- A. Penile doppler ultrasound of right corpora demonstrating normal arterial waveform.
- B. Right corporal biopsy demonstrating invasive urothelial carcinoma with lymphovascular invasion.

THE WRENCH – A STORY OF PHALLIC TRAUMA

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(Presentation to be made by Dr. Cohen)

Introduction: A 55 year old gentleman with a history of hepatitis C, HIV, and methamphetamine use, presented to the Emergency Room, with complaints of penile pain. Physical exam revealed a 13/16-inch Craftsmen box end wrench placed around the base of his penis, with significant edema of the distal shaft. He had been on a drug binge for the previous 48 hours, and did not have complete recollection of his actions. He was still able to void at the time of presentation.

Methods: Several maneuvers to move the wrench were attempted in the Emergency Room, including: manual compression, lubrication, compression of the shaft with a string in efforts to extract the device over the string, and placement of a 14-gauge angiocatheter needle tip through glans in efforts to drain the corpora. After all of these trials were unsuccessful, he was then taken to the operating room, where a Medtronic (Fort Worth, TX) Midas-Rex high-speed rotary device with a circular diamond-tipped blade was utilized to cut the box end wrench at two sites, approximately 180 degrees apart.

Results: The box wrench was successfully removed from the shaft of the penis; for safety, during the procedure, a small, malleable retractor was placed between the metal wrench and shaft of the penis, to protect the underlying skin. Copious cold-water irrigation was used to continuously bathe the wrench as well as the cutting blade. In addition, a sterile shield was placed over the penis and cutting instrument, to prevent sparks from igniting the surgical drapes or volatile anesthetic gases.

Conclusion: When taking the appropriate precautions, a rotary saw, with a circular diamond-tipped blade, serves as an effective means by which to remove a constrictive box end wrench from the shaft of a penis.

Source of Funding: None

PENIS ENLARGEMENT; A CAUTIONARY TALE

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(Presentation to be made by Dr. Brusky)

We report the first case of intractable priapism resulting in permanent erectile dysfunction in an otherwise healthy young man after taking an herbal male enhancement supplement likely adulterated with tadalafil.

FROM LIBYA WITH LOVE

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(Presentation to be made by Dr. Schlaifer)

Introduction: A 26 year old male physical therapy student at Loma Linda presented with left lower extremity and groin pain. He was visiting his family in Libya 2 months prior to his presentation, and was an innocent bystander during the country's civil unrest. Libya is a country in Northern Africa currently in a civil war which started earlier this year as a result of civil unrest and displeasure with the dictator Muammar Gaddafi and the people's desire for democratic elections.

Methods: The patient had an orchiectomy for a gun shot wound to his left testicle that he suffered in Libya. Subsequently, when he resumed his coursework for physical therapy school, he continued to have pain in the groin and drainage from the scrotal wound. Thus he presented to the emergency department for evaluation. At that time Urology was consulted and a bedside incision and drainage was performed, during which purulent material was expressed. The patient continued to have groin pain and drainage from this wound despite opening it, and further treatment was undertaken in the operating room to explore and debride the wound. The diagnosis of gossypiboma was made during exploration and the patient was treated accordingly. Pt's pain symptoms are much improved on two week follow up from his surgery.

Discussion: The incidence of gossypiboma varies from 1% of all surgical cases to 1/5000 patients in the general population. There is an associated mortality rate of 11-35%, however not all gossypibomas are harmful. Preventing a gossypiboma is possible, however prompt recognition and removal is key in treatment.

Source of Funding: None

AN INTERESTING CASE OF SCROTAL/LABIAL SCC AND SEMINOMA IN A PARTIAL ANDROGEN INSENSITIVE MALE

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(Presentation to be made by Dr. Zorn)

Background and Objective: We present an unusual case of scrotal/labial squamous cell carcinoma and seminoma of an incidental cryptorchid testicle in a 63-year-old partial androgen insensitive male with ambiguous genitalia. The patient was raised male and is partnered in a heterosexual marriage. Both are heavy smokers and employed as mixed farmers.

The patient presented on referral from orthopedics after he was noted to have an abnormal penis and scrotum with a cauliflower mass lesion at the time of total hip arthroplasty. The patient's history includes a remote laparotomy and multiple unknown procedures for severe hypospadias and micropenis.

Management and Results: On initial urologic evaluation, the feminent patient had no obvious urethral opening with either a micropenis or clitoromegaly and an introital opening with no palpable testicles. The tissue involving the labial folds or scrotum contained a lesion suspicious for Buschke-Lowenstein or extensive SCC and was secondarily infected. Excisional biopsy revealed well-differentiated invasive squamous cell carcinoma of the scrotum/labia. Initial staging CT abdomen/pelvis showed left sided inguinal lymphadenopathy, but no evidence of enlarged pelvic lymph nodes, other metastatic disease or cryptorchid testicles. The inguinal lymphadenopathy resolved with antibiotic therapy and thus the patient underwent a radical scrotoectomy and penectomy. Based on pathology, the patient underwent bilateral superficial and then radical inguinal and pelvic lymphadenectomies as well as an orchidectomy for an incidental left cryptorchid testicle. The pathology revealed 2 positive superficial lymph nodes on the right and seminoma of the left cryptorchid testicle.

Conclusions: This case presents a cascade of interesting pathology, starting with SCC of the scrotum; the management of which has recently been removed from some textbooks. It also serves to reiterate the strong propensity for lymphatic crossover that can occur with penile and scrotal SCC, as well as highlights the increased risk of testicular malignancy and need for orchidectomy in the androgen insensitive population. Furthermore, gender assignment presents an ethical dilemma in the patient with ambiguous genitalia. Our patient was raised a male and is involved in a heterosexual marriage. Interestingly, both he and his wife were equally pleased with the comparative cosmetic result of the patient's treatment.

BIGGER IS NOT ALWAYS BETTER: A REPORT ON A POTENTIALLY LIFE-THREATENING SEXUAL PRACTICE

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(Presentation to be made by: Dr. Hagedorn)

Purpose: Although scrotal inflation has been widely publicized on the Internet, it has not been discussed in the urologic literature. To date two case reports in the medical literature have been published on scrotal saline infusion as a cause of cellulitis. To our knowledge, we present the first case of Fournier's gangrene after recreational scrotal inflation.

Results: A 20yo man with no past medical history presented to the emergency room with a swollen, painful, and discolored scrotum. Approximately 36 hours prior to his admission he had recreationally infused one liter normal saline into his scrotum. He partook in this sexual practice together with a friend who had experience with scrotal inflation in the past. They reportedly used sterile technique and sterile needles and saline. The patient noted scrotal swelling and erythema one day after having inflated his scrotum and developed fevers/chills and increased scrotal pain the next day. On admission he was febrile to 104° Fahrenheit, tachycardic, hypotensive, and diaphoretic. The white blood cell count was 27,000/ μ L. On exam the scrotal skin around the entire median raphe appeared necrotic with cellulitis extending to the inner thighs and suprapubic area. A diagnosis of Fournier's gangrene was made and he was emergently taken to the operating room for scrotal debridement. The tissue was sent for culture, which grew beta-haemolytic streptococcus. He had been started on IV Zosyn and vancomycin in the emergency room, which was switched to oral clindamycin prior to discharge. The patient remained afebrile post-operatively and his WBC normalized. The scrotal wound was managed with wet-to-dry dressing changes and he was discharged three days later.

Conclusion: The prevalence of recreational scrotal inflation is unknown, but this sexual practice is widely discussed on websites. Given that people self-administer the infusion, infections are likely to be quite common, leading to cellulitis or even necrotizing fasciitis as in our case. Clinicians, in particular urologists, need to be aware of this unusual sexual practice. Additionally, patients who practice scrotal inflation should be educated about the potentially life-threatening complications.

Source of Funding: None

INTRATESTICULAR ABSCESS

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(Presentation to be made by Dr. Zaid)

Abstract: We present the case of a 24 year old immunocompromised man with an intratesticular abscess. The patient presented with one week of left scrotal pain and swelling. Work-up included scrotal ultrasonography which revealed a large fluid collection within the tunica albuginea of the left testis. Surgical exploration of the left testis evacuated a significant amount of purulent fluid. The residual viable testicular parenchyma was salvaged. Intraoperative cultures grew *Morganella morganii*. Follow-up ultrasonography showed resolution of the testicular fluid collection and the patient was discharged home with oral antibiotics. Intratesticular abscesses are a rare clinical entity that often result in orchiectomy.

Manuscript: A 24 year old male presented to the Emergency Department with one week of left testicular pain. His medical history included HIV and multiple prior admissions for cutaneous abscesses. He had previously undergone right orchiectomy for a scrotal abscess consuming the right testis.

On presentation, he was afebrile with normal vital signs. Physical exam revealed a swollen and erythematous left hemiscrotum. Urine and blood cultures were negative. A serum testosterone was 52 ng/dl. Scrotal ultrasonography (Figure 1) revealed a large central fluid collection within the tunica albuginea of the left testis.

The patient was started on broad-spectrum antibiotics and scrotal exploration was performed. Upon opening the tunica albuginea of the left testis, a significant amount of purulent fluid was evacuated (Figure 2). Culture of this fluid grew *Morganella morganii*. The remaining testicular parenchyma was salvaged. A Tiny Little Sucker (TLS) drain was placed in the testicular parenchyma and removed two days later. Follow-up ultrasonography showed resolution of the testicular fluid collection (Figure 3). The patient was discharged on oral antibiotics. Intratesticular abscesses are a rare clinical entity, typically occurring in immunocompromised patients and resulting from untreated epididymo-orchitis.(1) Although testicular salvage is possible, most cases of testicular abscesses result in orchiectomy.(2,3)

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SINGLE INCISION LAPAROSCOPIC ORCHIECTOMY, A CASE REPORT

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(Presentation to be made by Dr. Greene)

Purpose: Minimally invasive surgery is becoming the mainstay of the modern Urologist. Single-Incision laparoscopy is the next evolution in minimizing the morbidity and improving the cosmetic results of surgery. We describe our technique in the management of a post-pubertal male with intra-abdominal undescended testis.

Materials and Methods: A 32 year-old male with a unilateral undescended testis underwent a SILS Orchiectomy. Applied Gelport system was used through a curvilinear infra-umbilical incision. An Ethicon 10mm trocar was used as the camera port. Two 5mm Apple Core trocars were used as working ports. The testis was identified and dissected free using the EnSeal device. 5mm Endoclip applier was used to ligate the cord vessels. The testis was removed at the completion of the case with removal of the Gelport.

Results: The case was performed successfully through a single incision. Operative time was comparable to standard Laparoscopy. No complications were encountered while instrument interference was significant. There were no postoperative complications, and the incision has healed well.

Conclusions: Single-incision Laparoscopic Orchiectomy is a safe and viable option in the management of the post-pubertal undescended testis. A significant learning curve is required to gain proficiency while port and instrument technology is continuously improving.

Source of funding: None

30 BOOKS FOR THE GENERAL READER ABOUT PROSTATE CANCER HAVE BEEN PUBLISHED SINCE 1996; WHY SO MANY?

Anthony H. Horan, M.D.: Delano, CA
(Presentation to be made by Dr. Horan)

Introduction: In 2009, counting internet self-publishing and commercial 'houses', there were 290,000 new titles published in the United States. 200 new books a day come into Publisher's Weekly for review. Into this maelstrom, 30 books for the general reader about prostate cancer have been introduced since 1996. Why so many? To find an answer, the quantitative history was researched and a qualitative screen of the books devised was to diagnose the cause of the frenzy.

Materials and Methods: The first 27 titles to be found on the Amazon website for Prostate cancer plus the speaker's book, The Big Scare; the Business of Prostate Cancer, a Yale Press book by an M.D., and the most recent popular entry, The Invasion of the Prostate Snatchers, were selected. They were charted as to year of publication, authorship (lay, M.D, or both), bone marrow data, and approval of radical surgery and/or radical radiation.

Results: the numbers of books published per year increased from one per year in the '90's to a peaks of 4 per year in '05 and '09.

Table 1: Books per Year

#s	1	1	1	0	2	2	2	4	3	2	3	4	3
year	1996	1997	1999	'00	02	03	04	05	06	07	08	09	10

13 of 30 were authored jointly by M.D. and lay writers. 10 of 30 were M.D. alone efforts (3 Professors/Chairmen) and 6 of 30 lay persons only. Thus, 19 of 30, about 2/3's, had half lay or exclusively lay writers. 17 of 30 were in favor of radical surgery, 10 of 30 were in favor of radiation over surgery. In 6 the attitude could not be determined. Only one mentioned the presence of prostate cancer cells in the bone marrow of most men whose nuclear scan was negative preparatory to radical surgery, a Western Section observation. Only one urged fewer biopsies directed by PSA alone without a target nodule followed by limited cryosurgery to the.

Conclusion: (1) That 2/3's of the books are lay or partly lay authorship is evidence for discontent of the public with the management of this disease by the 'establishment'. (2) radical surgery is 'under the gun' more than radical radiation.(3) The accelerated production of books in the last five years suggests an adjustment of public opinion is immanent; it may be sympathetic to the American Cancer Society's new position that it has over promised on the benefits of early discovery of the common killers.

CAN A NEUROLOGICAL EXAM OF S1-S4 SUBSTITUTE FOR URODYNAMIC STUDIES PRIOR TO REPAIR OF STRESS URINARY INCONTINENCE?

Anthony H. Horan, M.D.: Delano, CA
(Presentation to be made by Dr. Horan)

Introduction: At the extension Western Section CME at Whistler, B.C., the presenter on stress urinary incontinence said that urodynamic data have not proved reproducible between laboratories. Thus, urodynamics, even though it is currently reimbursed by third parties, does not meet a baseline requirement for 'science.' Bors and Comar of U.C. Irvine in their book Neurological Urology suggested in the late 1960's that a neurological exam of S1-S4 should be done in all patients with urinary incontinence. The hypothesis governing this report says their neurological exam is sufficiently sensitive to exclude anti-incontinence procedures doomed to fail.

Methods: A review of patients with stress incontinence in a private practice using codes for cystoscopy and stress urinary incontinence in 2009-2010 yielded 10 patients with a complete neurological exam S1-S4 done prior to any sedation or anesthesia. A finger was inserted in the anus to assess the first four reflexes. The bulbocavernosus is recorded via an anal contraction after a pinch of the clitoris. These reflexes tests are followed by pinprick of the perineum and deep tendon reflexes of the lower extremity.

Results: Morbid obesity was present in 5 of 10, suprapubic tap in 4 of 10, voluntary contraction in 8 of 10, cough in 8 of 10, bulbocavernosus in 4 of 9, pin prick of perineum in 8 of 10, knee jerk right in 7 of 9, knee jerk left 6/9, ankle jerk right in 4 of 9, ankle jerk left in 2 of 8. In the five that were not morbidly obese and so had the Stamey-Pereya anti-incontinence procedure, there were no surprise failures post-operatively.

Conclusion: the neurological exam of S1=S4 is rarely normal in incontinent women, particularly the morbidly obese with attendant diabetes. Failure of the bulbocavernosus reflex (4 of 10) and the ankle deep tendon reflexes (4 of 9) is noteworthy in this series. No case of detrussor hyperreflexia, as in multiple sclerosis, was missed. Absent pin prick of the perineum was a good guide to cauda equina syndrome. The Bors and Comar neurological exam can be safely substituted for urodynamics prior to repair of stress urinary incontinence. Cost savings nationwide could be substantial.

HERPES ZOSTER (SHINGLES) OF THE BLADDER WITHOUT SKIN VESICLES OR RETENTION: HOW MANY OF THESE HAVE I MISSED IN 37 YEARS?

Anthony H. Horan, M.D.: Delano, CA
(Presentation to be made by Dr. Horan)

Introduction: That H. Simplex and H. Zoster can present as urinary retention accompanied by skin vesicles in the sacral dermatomes is well published. But, the most recent 10 entries in PubMed describe urodynamic findings on such patients, but not cystoscopy for diagnosis.

Case Report: a 73 y.o. retired R.N. presented after three months of self medication for a dull ache in the bladder. 6 months before she had had a successful Stamey-Pereya repair of stress urinary incontinence by the same urologist. A cystoscopy was done to exclude late erosion of the nylon retention suture into the bladder. There was no penetrating suture. Instead, the bladder showed old, purple, flame shaped hemorrhages in a radicular distribution throughout. Within the 'flames' 1-2mm, white, ulcers were present... H. Zoster titers were ordered on that day and in 6 weeks. The herpes titers were high on the day of the cystoscopy. The chronic pain disappeared after 5 days of Acyclovir. The herpes titers at 6 weeks had descended to normal. The patient, a knowledgeable R.N., was grateful for the quick improvement and learned from outsider sources of a new immunization against a repeat attacks of shingles..

Conclusion : (1) Urologists may be mistaking H. Zoster for bacterial hemorrhagic cystitis and ordering antibiotic, not antiviral, therapy. (3) Neurologists, physiatrists, and E.R. specialists seem to be making the diagnosis via urodynamic exams instead of by cystoscopy according to a current review of PubMed. (2) Urology should be more conscious of this protean disease and ready with a therapeutic trial of Acyclovir.

THE MATRYOSHKA STONE

Timothy J. Tausch, M.D. and Timothy C. Brand, M.D.: Tacoma, WA
(Presentation to be made by Dr. Tausch)

Case: Herein, we present the first case of the matryoshka (Russian nesting doll) stone reported. This interesting and unique entity has yet to be reported in the urologic literature.

FEASIBILITY STUDY: A NOVEL ULTRA-SMALL GOLD MICRO-TYNED FIDUCIARY MARKER DESIGN AND DELIVERY PROTOCOL TO IMPROVE CONFORMAL RADIATION THERAPY FOR BLADDER CANCER

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(Presentation to me made by Dr. Garcia)

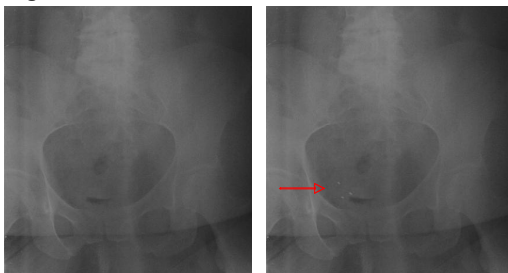
Background and purpose: Bladder radiation is an important management option for carefully selected patients with bladder cancer. However, poor visualization of the bladder on CT imaging and day to day variation in bladder volume and wall location limit targeting efficacy and increase morbidity. Currently, the smallest area that can generally be targeted to receive higher (boost) radiation dosage is $\frac{1}{4}$ of total bladder area. More accurate and reliable target localization would likely improve treatment outcomes.

Materials and Methods: Six consecutive patients with stage T2 bladder cancer elected management with combination radiation-chemotherapy. All underwent endoscopic placement of modified 24-K gold fiduciary markers (1.1 mm. x 3.2 mm., and 0.65 mm. x 2.1 mm.) into healthy submucosa 1 cm. from the resection margin around the tumor resection site using a custom-made steel coaxial needle. Retention and migration was confirmed by KUB, dosimetry-planning CT-scan, and portal imaging. Patients were assessed for adverse effects of marker placement.

Results: Between January 2007 and March 2011, a total of 39 markers (3-5 per tumor site) were placed into 10 patients (6 men, 5 women, mean age 79.5 and 72.75 years, respectively). All markers were easily visualized by KUB, CT scan, and portal imaging; marker migration was not detected. One patient (3 markers) ultimately underwent surveillance only, and did not commence radiotherapy. One other patient (4 markers) is awaiting commencement of radiation therapy. Eight patients (32 markers) completed radiation therapy. In 1 patient, during the last quarter of radiation therapy, 1 of 4 markers placed fell-out (was voided). All other markers (31/32) (97%) were present through the end of radiation therapy. No intraoperative or post-operative complications occurred. We estimate that the presence of the micro-tyned fiduciary markers allowed the area targeted to receive higher-dose radiation to be reduced to $\frac{1}{2}$ to $\frac{1}{6}$ of the area that would be irradiated *without* the markers.

Discussion: The novel micro-tyned fiduciary marker, Gelfoam Plug design and placement protocol we present is technically simple to perform, well tolerated, and designed to minimize risk of marker migration. This allows the exact site of bladder tumor resection to be localized in 3-dimensions throughout dosimetry planning and therapy, while minimizing the high (boost)-dose treatment area.

Figure 1



THE CROWN TEST: A NEW DIAGNOSTIC TOOL FOR ENTERO-VESICAL FISTULA

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(Presentation to be made by Dr. Cheney)

Purpose: To develop a new minimally-invasive test to help diagnose an Entero-vesical fistula.

Materials and Methods: A 79 year-old female presented to the hospital with recurrent urinary tract infections, fecaluria, and hematuria. Entero-vesical fistula was suspected so a urologic consultation was obtained. Past medical history was significant for stroke, Parkinson's disease, dementia, bilateral hip fractures with hip replacement, and prior hysterectomy. We initially considered using the charcoal test where activated charcoal is administered orally and seen in the bladder, however the results were not visually appealing. The Skittles® test, where the colorful candies are swallowed and then found in the bladder, was then attempted but the rainbow treats lost their luster in the long voyage through the GI tract. Finally, our patient came up with her own solution: The Crown Test, a validated tool to aid urologists in the diagnosis of entero-vesical fistula.

Results: CT Urography was significant for sigmoid diverticulitis and right hydronephrosis, however the pelvis was obscured by her artificial hips. After self administration of upper molar number 15, our patient was taken to the operating room for cystoscopy. Evaluation revealed several pieces of stool as well as her golden crown within the bladder. The miraculous tooth had travelled through the intestines, into the fistula and entered the bladder. The diagnosis was confirmed. Several days later, she was taken back to the operating room for sigmoid colectomy and end colostomy. Pathologic analysis showed multiple fistulous tracts as well as extensive diverticulitis and "tooth". The patient recovered quickly and was subsequently discharged home.

Conclusions: The Crown Test is an effective and validated aid for the diagnosis of entero-vesical fistula. Larger studies will be needed to confirm our findings.

Source of Funding: None

A TRICK OF THE TRADE FOR WHEN YOU CAN NOT REMOVE A URETERAL STENT

Gene O. Huang, M.D., Forrest C. Jellison, M.D., Gideon D. Richards, M.D., Gautum Agarwal, M.D., D. Duane Baldwin, M.D.: Loma Linda, CA
(Presentation to be made by Dr. Huang)

Ureteral stent placement is frequently employed in Urologic practice. Removal of a stent is rarely a complicated endeavor. There are, however, situations where the complexity of removal is increased (e.g. encrustation). One particularly rare situation is where the proximal coil of the stent loops around its end to form a knot. A knot increases the cross sectional area of the stent which is often great enough to become lodged within the ureteropelvic junction greatly increasing the complexity of removal.

This round table discussion and video demonstrate a particularly simple solution to this complex problem. Using a tool readily available in most cystoscopy suites, the Urologist can untangle what would otherwise be a Gordian knot and minimize the risk of ureteral injury and avulsion during removal.

RENAL TRAUMA IN AN INTERESTING ANATOMIC VARIANT

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(Presentation to be made by Dr. Gannon)

Purpose: Crossed Fused Renal Ectopia is a rare condition; further Ureteropelvic junction obstruction in this setting is even more uncommon. In our paper a male patient is presented who had left sided-crossed fused renal ectopia with the above-mentioned UPJ obstruction. This patient underwent a low-grade blunt abdominal trauma. During initial evaluation, based upon A CT scan obtained because of gross hematuria, the patient was found to have a urine leak. The patient's CT scan showed no other evidence of other intraabdominal trauma. In this case report, we discuss management of blunt trauma in this interesting anatomic variant.

Methods: A chart review including, intraoperative intervention, floor care and follow up appointments, after the initial evaluation for care in our Urology subspecialty clinic.

Results: Our patient is a 32-year-old male that underwent a low velocity blunt abdominal trauma and was found to have a urine leak/urinoma. He was hemodynamically stable but did have a slow progressive decline in hematocrit through his hospital stay secondary to hematuria. A transfusion was not required. Secondary to abdominal pain, ileus and persistent urinary leak, the patient was taken to the operating room for ureteral stent placement and retrograde ureteropyelograms on day 3 of his hospital stay. As the imaging in our presentation will show the patient had a variant known as L shaped crossed fused renal ectopia with the renal pelvis sitting with an anterior lie and prominent ureteropelvic junction obstruction, presumably from the anatomic nature of his kidney. A significant urinoma, developed with this blunt low-grade trauma.

Examining the patient's anatomy more closely, his left renal pelvis has an anterior lie, exposing it to greater risk of traumatic injury. This is additionally increased as his ureteropelvic junction obstruction further increases his risk for traumatic injury. Distension of the renal pelvis causes greater surface tension and the ability for a low grade, low velocity renal injury producing urinary extravasation.

Conclusion: The patient remained hospitalized for seven days. He did undergo surgical intervention with ureteral stent placement on hospital day three. The indwelling ureteral stent managed this urine leak successfully, in the setting of his ectopic ureter and UPJ. The patient remained stable throughout his hospitalization and follow up ultrasound showed resolution of the urinoma, however his ureteropelvic junction obstruction still remains.

TEN QUESTIONS

John M. Barry, M.D., Portland, OR
(Presentation to be made by Dr. Barry)

10. Why are small, benign renal masses treated?
9. Is the better kidney always left with the laparoscopic renal donor?
8. Why don't urologists wait as long between nerve blocks and prostate biopsies as dentists do between nerve blocks and working on teeth?
7. Why do urologists do TRUS-guided prostate biopsies through stool?
6. Why do we do TRUS-guided saturation biopsies of the prostate?
5. What are acceptable positive margin rates after radical prostatectomy for low and intermediate risk cancers?
4. Is it time to rediscover estrogen as primary androgen-deprivation therapy for prostate cancer?
3. Why don't all practice guidelines use a uniform grading system?
2. Why is "stone-free" an accepted expression of a clinical result?
1. Why do speakers use a Mac when Windows is the format for a meeting?