

## POS-02.114

**Tubularized incised plate as first choice of therapy for hypospadias**Mustafa M<sup>1</sup>, Abol-Enein H<sup>2</sup><sup>1</sup>*Osmaniye State Hospital, Urology Department, Osmaniye, Turkey;* <sup>2</sup>*Urology and Nephrology Center, Mansoura University, Mansoura, Egypt***Purpose:** To evaluate the validity of tubularized incised plate (TIP) urethroplasty technique for proximal, distal, primary, secondary and complicated cases of hypospadias.**Material & Methods:** From June 2002 to December 2003 and from March 2006 to January 2007 total of 36 patients aged 1-22 years (average 7.5) were operated using the concept of TIP urethroplasty. Data on patients is in table 1. The standard TIP urethroplasty was performed in the primary cases (26 patients) while in the secondary cases (4 patients) and in the boys who were circumcised before admission (6 patients), modified TIP urethroplasty were used. In patients with chordee, hypospadias repair and chordee release was done at one stage. The mean period of hospitalization and follow up were 0.92 days and 4.19 months respectively.**Results:** No fistula was observed in boys who underwent primary reconstruction using standard TIP urethroplasty. Fistula was observed in two patients (5.55%); One patient with penoscrotal hypospadias who underwent 2-stage repair, and another one was circumcised before admission. One patient had meatal stenosis at the early postoperative period which was corrected by dilatation of the external meatus by feeding catheter at intervals up to two months postoperatively. Three boys had very narrow fistula which just allow leaks of few drops of urine through urination which was closed spontaneously within two months.**Conclusion:** Standard TIP urethroplasty is the procedure of choice for the treatment of primary cases of proximal hypospadias and, the concept of this technique seems

to be suitable for distal, secondary and even complicated hypospadias reconstruction. The advantages of this procedure include its simplicity, low complication rates and very good appearance of the glans with normal meatus.

## POS-02.115

**Avagard™ in pediatric urological surgery: safe, effective and time efficient**

Palmer JS

*Glickman Urological Institute, Cleveland Clinic, Cleveland, OH, USA***Introduction:** Avagard™, chlorhexidine gluconate 1% solution and ethyl alcohol 61% w/w is a waterless, scrubless, and brushless hand antiseptic indicated as a replacement for traditional pre-surgical brush hand scrubbing. We compared Avagard to hand brush scrub preparation by the urologist in preparation for outpatient and inpatient pediatric urological operations.**Methods:** We evaluated the first 900 patients that we used Avagard as a preoperative hand antiseptic and compared them to the last 900 consecutive patients that we performed traditional antiseptic-impregnated hand brush scrubbing. A pediatric urological procedure was performed on each child. Patients and surgeon were monitored for side effects, and patients were monitored postoperatively for signs of wound infection. A cost analysis of the use of Avagard as compared to an antiseptic-impregnated hand brush for preoperative hand preparation was performed.**Results:** No side effects for the patient or surgeon were noted including allergic reaction or skin irritation in either group. The incidence of wound infection was 1 in the Avagard group and 2 in the hand-scrub group (not statistically significant). A single course of oral antibiotics successfully treated all wound infections without any long-term sequelae. The use of Avagard was cost effective and more time efficient.**Conclusion:** This study demonstrates that Avagard is a fast, easy to apply, effective, and safe surgical hand preparation for pediatric urological surgery. Its use is time efficient as well as cost effective in relation to the traditional surgical scrub.

## POS-02.116

**A simple and reliable formula for determining the proper JJ stent length in the pediatric patient: Age + 10**Palmer JS<sup>1</sup>, Palmer LS<sup>2</sup><sup>1</sup>*Glickman Urological Institute, Cleveland Clinic, Cleveland, OH, USA;* <sup>2</sup>*Schnei-**der Children's Hospital, North Shore-Long Island Jewish Health System, New York, NY, USA***Introduction:** The length of a double J stent inserted in children following various types of surgeries is often determined empirically. What would be helpful to a urologist treating children is an accurate and easy to recall mathematical relationship between stent length and another parameter. We evaluated if such a relationship exists between appropriate JJ stent length and the age of the child.**Methods:** We reviewed the ages and JJ stent length used in all children over the past 6 years. The proper stent length was defined as a gentle curve of the proximal coil within the renal pelvis (fluoroscopically or ultrasound) and the distal coil within the bladder (direct vision). The data were stratified according to gender and laterality, and then regression analyses performed between patient age and stent length.**Results:** There were 191 patients who were stented during this time period. The surgeries for which a stent was used included ureteral reimplantation, stone disease, and renal surgery. The age ranged from 2 months to 17.9 years. The regression analyses demonstrated consistent and reliable (r<sup>2</sup>) relationships between patient age and JJ stent length irrespective of laterality or gender. The general relationship is: STENT LENGTH = PATIENT AGE (yrs) + 10.**Conclusion:** This study demonstrated that an accurate and reliable "rule of thumb" to determine proper length of JJ stent in children, irrespective of gender or laterality, is simply adding 10 to the patient's age.

## POS-02.117

**Clinical evaluation of 47 boys with nonpalpable testis**

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*Department of Urology, Faculty of Medicine, University of Miyazaki, Kiyotake, Japan***Purpose:** We assessed the accuracy of contralateral testis hypertrophy for predicting monorchia in patients with a non-palpable testis.**Material:** From 1996 to 2005 we evaluated 47 patients for unilateral non palpable. The age range was 5months to 8 years. The non palpable status of the side in question was confirmed by physical**Table 1. POS-02.114:** The clinical characteristics of the patients in terms of age, diagnosis, presence or absence of chordee, hospitalization and follow-up periods

Age (year)	7.5 (1-22)
Distal hypospadias (n)	28 (77.77)
Midshaft hypospadias(n)	4 (11.11%)
Penoscrotal hypospadias (n)	4 (11.11%)
Chordee(n)	4 (11.11%)
Hospitalization period (day)	0.92 (0-3)
Follow-up (month)	4.19 (3-12)