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AB135. Efficacy of extracorporeal shock wave therapy for the treatment of Peyronie's disease: a meta-analysis

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Objective: Extracorporeal shock wave therapy (ESWT) is an attractive treatment for Peyronie's disease (PD), while its effectivity for PD still remains controversial.

Methods: We conducted a search of PubMed, MEDLINE, EMBASE for available literatures published before June 2014. To access the treatment of ESWT for PD in penile pain, plaque size, deviation angle, intercourse function.

Results: Seven studies were finally assessed in our meta-analysis. When compared ESWT with control for penile pain, the remission rate was significantly higher (OR =1.78, 95% CI, 1.34-2.35), unchanged pain rate were significantly less (OR =0.51, 95% CI, 0.30-0.89) and aggravation pain rate was less (OR =0.38, 95% CI, 0.12-1.17). The pooled odds risk for reduced deviation angle rate was (OR =1.36, 95% CI, 0.80-2.31) in the ESWT group vs control, which indicates no statistical significance. Contractible or disappeared plaque rate after ESWT were significantly higher than in control group (OR =2.42, 95% CI, 1.74-3.37). There was no significant difference for the rate of possible intercourse patients between ESWT and control group (OR =1.32, 95% CI, 0.42-4.17). Moderate intercourse rate were significantly lower after ESWT vs. control group (OR =0.65, 95% CI, 0.42-0.99). Impossible intercourse rate were no statistical significant difference (OR =0.811, 95% CI,

0.42-1.58).

Conclusions: ESWT could alleviate penile pain and reduce or soften PD plaque. The intercourse or erectile function may subjectively improve after ESWT. However, there is no significant influence for penile deviation. More high-quality RCTs are required to verify the findings.

Keywords: Meta-analysis; extracorporeal shock wave therapy (ESWT); Peyronie's disease (PD)

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AB136. Successful penile replantation following penile self-amputation: case report and literature review

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Objective: Penile amputation is an uncommon injury resulting from self-mutilation, felonious assault, or accidental trauma. Although it is uncommon and rarely fatal, penile amputation is a challenging injury for Urologist to treat. Many factors should be taken into consideration of proper treatment. In this kind of patients, the mental and physical conditions are usually complicated. Rapid stabilization is very important to afford the appropriate time and specialization for surgical success. Currently, many reconstructive techniques provide an excellent outcome for penile replantation. We reported a case of soft palate squamous cell carcinoma under palliative chemotherapy who amputated his penis at the base with a sharp blade due to severe depression.

Methods: A 66-year-old man with soft palate squamous cell carcinoma, pT2N0M0, post surgery and local recurrence, was under palliative chemotherapy now. Two days before

this emergent episode, he was just admitted due to dyspnea and electrolytes imbalance. He decided to discharge against advice before completing the treatment. After lunch, he locked himself in the bathroom and used kitchen knife to mutilate his penis. He was brought to our emergency department by his family. A clinical examination found a bloody and destroyed penis. One small piece of penile appendage was connected with actively bleeding penile stump by one side of prepuce. The exploratory surgery showed a complete transection of corpus cavernosum, corpus spongiosum, and urethra. A 14-French silicon catheter was threaded through the glans and aligned with the proximal urethra. We began with interrupted 4-0 Vicryl sutures in a 360-degree fashion to connect urethra. Interrupted 4-0 Vicryl sutures were placed from ventral side of the tunica albuginea of the corpus spongiosum. Till the dorsal aspect of amputated penis, we carefully applied tension-free, interrupted 4-0 Vicryl sutures to reapproximate the tunica albuginea of the corpus cavernosum. A pressure dressing was placed around the anastomosis wound. After surgery, the patient was taken daily wound care.

Results: Penile amputation is a rare urologic emergency. The actual incidence of penile amputation is rare. The first documented case of macroscopic penile replantation was reported in 1929 by Ehrlic. Since then, there have been gradual rise of traumatic penile amputation with 87% of cases reported associated with an underlying psychotic disorder. A review of the literature revealed at least 30 cases of penile auto-amputation with successful replantation since 1970. Treatment of penile amputation includes three basic forms: surgical replantation of the amputated penis, tailoring of the remaining penile stump, or total phallic replacement. Many factors will lead to positive final **results:** the degree of injury, type of injury, duration of warm ischemia, the equipment used, and experience of the operative team. Most outcomes reported till now were acceptable.

Conclusions: Penile amputation is an extremely rare urology emergency. We reported that a macrosurgical technique without microsurgical venous repair is able to restore normal urinary function in a case with penile amputation and complete urethra injury and partial corpus spongiosum injury.

Keywords: Penile self-amputation; genital self-mutilation; penile replantation; external genital injury

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AB137. The efficacy of a new vasovasostomy technique in the rat

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Objective: To observe the efficacy of a new vasovasostomy technique with running suture on the back wall and interrupted suture on the anterior wall of vas in the rat.

Methods: Ten Sprague Dawley rats, aged 3-6 month, were used. Rat was anesthetized, and abdomen was opened, vas was dissected and cut, then vasovasostomy was performed with the new technique. At first the back wall of vas was performed continuous running-suture on the mucosa and inner muscle with 10 "0" nylon silk, then the anterior layer was interruptedly sutured, at last the seromuscular layer was sutured on the anterior wall and then on the back wall. After anastomosis, vas was cut from 1 cm distant from anastomotic site, testis and epididymis were gently pushed to observe if seminal fluid was flowing out of the vas, and then examined with a microscope to confirm if sperms existed. At last vas was cut near the epididymis and a needle was inserted into the vas lumen with the distant section of vas closed with a forceps, and saline was injected into the vas to observe if there was water leakage around the anastomotic site. Vas at the other side was managed with the same procedure above.

Results: A total of 20 vases in 10 rats were anatomized successfully with operation time from 30-90 minute. Patency was confirmed with both sperm existing at the distant anastomotic site and water testing without leakage.

Conclusions: The new vasostomy technique, with continuous running suture at the back wall and interrupted