Poster Session 11: Sexual Health, Infertility
Monday, July 1, 2024 • 7:00–8:30

Cite as: *Can Urol Assoc J* 2024;18(6Suppl1):S119-28. http://dx.doi.org/10.5489/cuaj.8836

MP 11.1

A comparison of primary gender-affirming vaginoplasty outcomes: Penile inversion vs. robotic-assisted peritoneal flap

Michaela Sljivich[1], Dan Kahan[2], Chantal J. Allan[3], Miroslav Djordjevic[1], Rajveer Purohit[1]
[1]Department of Urology, Icahn School of Medicine, Mount Sinai, New York, NY, United States; [2]Albert Einstein College of Medicine, Bronx, NY, United States; [3]Division of Urology, Department of Surgery, University of Alberta, Edmonton, AB, Canada

Introduction: Robotic-assisted peritoneal flap vaginoplasty (PFV) for feminizing gender-affirmation surgery is an alternative to penile inversion vaginoplasty (PIV) for transgender females (TF). There is little data on comparative outcomes complicating preoperative discussions to help direct patient choice. We compared perioperative and postoperative outcomes in patients undergoing PFV and PIV at a single institution.

Methods: Forty-one TF who underwent primary PIV were compared to 41 TF who underwent PFV at a single center. Retrospective data was collected to assess preoperative penile skin length to the coronal sulcus, vaginal depth 1 month and 6 months postoperatively, operative time (OT), estimated blood loss (EBL), length of hospital stay (LOS), perioperative complications, 30-day emergency department visits, and late complications requiring surgical revision. Variables were directly compared for PFV and PIV using parametric t-tests.

Results: The PFV and PIV groups were similar in age, BMI, and presence of circumcision (61% vs. 58%, respectively). The PFV group had shorter penile length to coronal sulcus (7.0 cm [1.0–11] vs. 9.0 cm [6.0–13]), less EBL (250 cc [150–500] vs. 300 cc [150–700]), and similar LOS (3 days [1–18] vs 3 days [2–6]) and OT (339 min [269–447] vs. 365 min [249–524]) compared to the PIV group. Intraoperatively, there were 3 rectal injuries (RI) during PIV and none during PFV. Among the three patients with RI, 1 underwent diverting ileostomy. PFV patients had a lower risk of transfusions than PIV (2.44% vs. 9.75%). PFV and PIV experienced similar 30-day ED visits (17.1 vs. 17.1%), hospital readmissions (7.32 vs. 7.32%), and late complications requiring surgical revision (12.2 vs. 14.6%). The PFV group had deeper vaginal depth after 1 month (18 cm [13–20] vs. 15 cm [4.0–23]) and 6 months (18 cm [7.6–20] vs. 15 cm [2.5–19]). The ratio of vaginal depth after 1 month compared to penile length was greater in the PFV group (2.5 [0–18] vs. 1.7 [0.46–2.5]).

Conclusions: In this cohort, PFV led to improved vaginal depth as compared to PIV, despite shorter preoperative penile skin length. These findings suggest PFV is advantageous in TF with shorter penile length desiring greater vaginal depth. Bowel complications were lower among TF who underwent PFV vs. PIV. PFV may confer an advantage in operative time and blood loss compared to PIV, with a reduced need for transfusion in the postoperative setting. Further studies are needed to determine long-term outcomes of vaginal depth, the comparable safety profile in this study supports the use of primary PFV as an alternative to PIV.

Acknowledgements: Abstract has been submitted to the American Urological Association Annual Meeting. Decision pending at time of submission.

MP 11.2

Adolescent and young adult microsurgical varicocelectomy and sperm parameter enhancement: A prospective, matched-cohort analysis

Francis Petrella[1], Adele Raymo[1], Iman Sadri[2], Vinayak Madhusoodanan[1], David Velasquez[1], Nicholas Deebel[1], Daniel Nassau[1], Joshua White[3], Ranjith Ramasamy[1]
[1]Desai Sethi Urology Institute, University of Miami, Miami, United States; [2]Division of Urology, McGill University, Montreal, Canada; [3]Department of Urology, Dalhousie University, Halifax, Canada

Introduction: Varicocele is known to be associated with impaired semen parameters and male infertility in adults; however, its impact on the adolescent and young adult (AYA) population is less well understood. This study aimed to assess the improvement in sperm parameters following varicocelectomy in the AYA population, comparing them to matched adult counterparts, and investigating potential advantages of early intervention.

Methods: A prospective analysis was conducted using a comprehensive database at the University of Miami spanning from 2010–2022. We defined AYA as males 25 years of age or younger who underwent varicocelectomy. To ensure comparability, they were matched with adult patients (over 30 years of age) based on follicle-stimulating hormone (FSH) values, varicocele grade, and laterality (unilateral or bilateral) in a 1:2 ratio. Semen parameters were evaluated before and after surgery, including sperm count, motility, morphology, and overall semen quality.

Results: We included 45 patients in the AYA group and matched them with 116 adults, all of whom underwent microsurgical varicocelectomy (Table 1). Both groups demonstrated improvements in semen parameters compared to their respective baselines (Table 2). Postoperative FSH levels in the AYA group were significantly lower than in adults, 4.05 and 6.2, respectively (p=0.007). Furthermore, postoperative sperm concentration in the AYA men demonstrated a remarkable increase, with a median of 16 mill/ml, compared to 9 mill/ml in the adult group (p=0.009). Additionally, motility displayed significant enhancement among the AYA men, with a median of 53%, surpassing the adult cohort's median motility of 41% (p=0.002).

Conclusions: This study highlights the potential benefits of varicocelectomy as a viable treatment option for adolescents and young adults with varicocele, particularly those with impaired semen parameters. By intervening at an earlier stage of development, patients in this age group can achieve significant improvements in semen quality, as compared to their adult counterparts.

MP 11.2. Table 1. Baseline characteristics

	AYA (n=45)	Control (n=116)	p
Age, years, mean (SD)	20 (1.33)	37 (6.0)	**<0.001**
Reason for consult, n (%)			**<0.001**
Orchialgia	22 (48.89%)	22 (19%)	
Physician finding	2 (4.44%)	1 (0.86%)	
Patient finding at palpation	4 (8.89%)	0	
Infertility	10 (22.22%)	104 (89.66%)	
Abnormal Semen analysis	9 (20%)	6 (5.17%)	
Recurrence	3 (6.67%)	0	
Decreased testicular function	1 (2.22%)	0	
Laterality, n (%)			**0.013**
Left	30 (66.67%)	48 (41.38%)	
Right	0	0	
Bilateral	15 (33.33%)	66 (56.90%)	
NA	0	2	
Severity of varicocele Right			0.433
Gr 1	7	17	
Gr 2	7	37	
Gr 3	1	4	
Severity of varicocele Left			**<0.001**
Gr 1	2	10	
Gr 2	14	63	
Gr 3	29	32	
Prior intervention, n (%)			**<0.001**
Yes	5 (11.36%)	0 (0%)	
No	39 (88.64%)	115 (100%)	
Testicular size, cc, mean (SD)			
Right	15.33 (4.21)	14.44 (2.96)	0.203
Left	14.95 (3.21)	14.37 (2.96)	0.282
Total testicular volume	30.29 (7.12)	28.74 (5.84)	0.168
Preoperative labs			
FSH, median (IQR)	4.2 (2.55–7.04)	5.5 (3.7–7.9)	**0.045**
LH, mean (SD)	5.11 (2.22)	4.94 (2.64)	0.321
Testosterone, mean (SD)	494.77 (202.22)	413.48 (139.80)	**0.028**
17-OH, mean (SD)	121.17 (52.29)	80.45 (37.30)	**0.007**

MP 11.2. Table 1 (cont'd). Baseline characteristics

	AYA (n=45)	Control (n=116)	p
Preoperative semen analysis			
Volume, ml, mean (SD)	2.12 (1.73)	2.74 (1.38)	**0.019**
Concentration, mill/ml, median (IQR)	9 (5–18)	6 (2–13)	0.276
Motility, %, median (IQR)	45.5 (26.75–55)	34.5 (22.75–46)	0.097
TMSC, mean (SD)	11.66 (14.56)	8.78 (10.72)	0.236

MP 11.2. Table 2. Perioperative findings

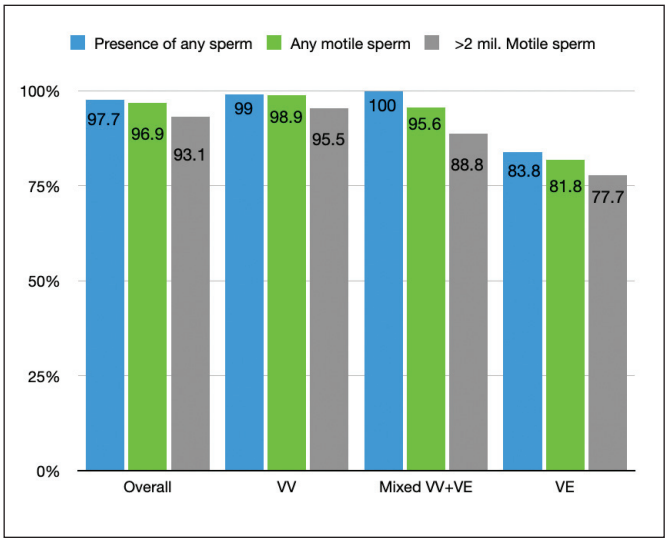
	AYA (n=45)	Control (n=116)	P-value
Surgical approach, n (%)			
Open	0 (0%)	0 (0%)	1.000
Inguinal/subinguinal microscopic	45 (100%)	116 (100%)	
Laparoscopic	0 (0%)	0 (0%)	
Laterality, n (%)			**<0.001**
Left	31 (70.45)	46 (39.66)	
Right	0	0	
Bilateral	13 (29.55)	70 (60.34)	
Intraoperative complications, n (%)			
Yes	0 (0%)	0 (0%)	1.000
Postoperative labs			
FSH, median (IQR)	4.05 (2.65–7.28)	6.2 (4.7–10.4)	**0.007**
LH, mean (SD)	3.67 (1.59)	5.34 (3.00)	**0.003**
Testosterone, mean (SD)	462.51 (189.66)	456.09 (203.70)	0.897
17-OH, mean (SD)	85.75 (51.72)	74.62 (43.84)	0.484
Postoperative semen analysis (SD)			
Volume, ml, mean (SD)	2.73 (1.86)	2.78 (1.38)	0.879
Concentration, mill/ml, median (IQR)	16 (9–27)	9 (3.75–16.25)	**0.009**
Motility, %, median (IQR)	53 (44–60)	41 (29–52.5)	**0.002**
TMSC, mean (SD)	26.23 (28.65)	14.13 (17.18)	**0.010**
Postoperative complication n (%)			**0.029**
Pain	0	16 (13.91)	
Hydrocele	1 (2.33)	1 (0.87)	
No complication	42 (97.67)	98 (85.22)	

MP 11.3

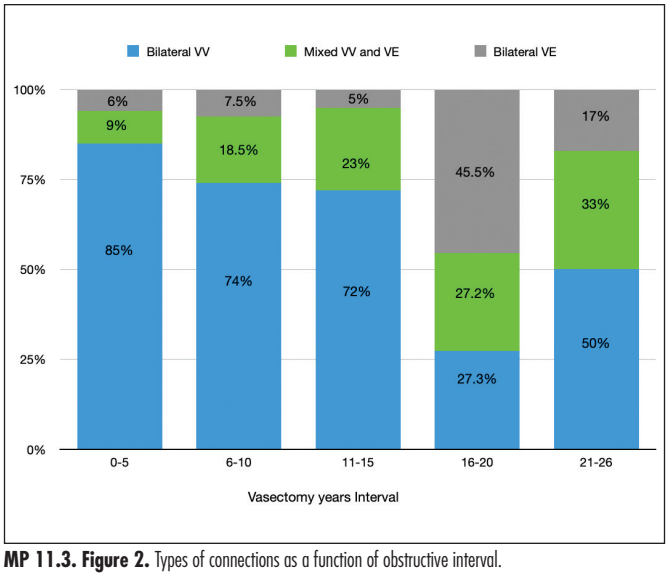
Outcomes using a novel tension-relieving hitch in microsurgical vasectomy reversals

Abdullah Alhamam[1,2,3], Ryan K. Flannigan[1,2,4], Kiera Liblik[5], Luke Witherspoon[6]
[1]Department of Urologic Sciences, The University of British Columbia (UBC), Vancouver, Canada; [2]Vancouver Prostate Centre, The University of British Columbia (UBC), Vancouver , Canada; [3]Department of Urology, Imam Abdulrahman Bin Faisal University (IAU), Dammam, Saudi Arabia; [4]Department of Urology, Weill Cornell Medicine, New York, United States; [5]School of Medicine, Queen's University, Kingston, Canada; [6]Division of Urology, University of Ottawa, Ottawa, Canada

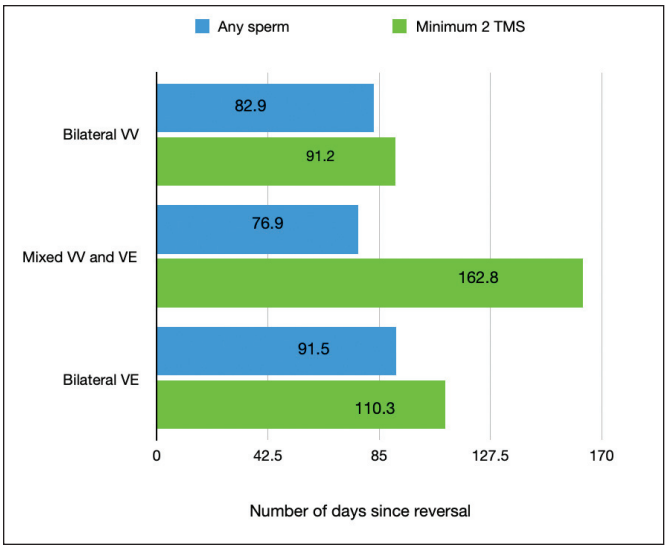
Introduction: Vasectomy reversals (VR) are commonly performed microsurgical procedures. Tension on the anastomosis is believed to be a contributing factor to failure. This study reports VR outcomes using a novel technique introducing a tension-relieving hitch along with a modified geometric multilayer microdot vasovasostomy (VV) procedure, longitudinal intussuscepted vasoepididymostomy (VE), and mixed VV+VE procedures.



MP 11.3. Figure 1. Patency rates.



MP 11.3. Figure 2. Types of connections as a function of obstructive interval.



MP 11.3. Figure 3. Number of days since reversal.

Methods: All VR patients since 2018 were reviewed. Inclusion criteria included patients who underwent a VR, with at least one semen analysis within six months of surgery and a minimum of six months of followup after the surgery to deem a failure. The primary outcome was patency, which is defined classically as any sperm in the ejaculate and functionally as at least two million motile sperm. Late failure is defined as an azoospermic semen sample after previously documented presence of sperm.

Results: A total of 159 patients underwent a VR between June 2019 and September 2023; 136 patients met the inclusion criteria. The patency rate among all VRs (VV, VEs, and mixed VV-VEs) was 97.7%. The overall functional patency rate was 93.1%. One hundred and one patients underwent bilateral VVs, with a 99% patency rate and 95.5% functional patency rate. The mean time to achieve patency was 82.9 days. Only four patients had a late failure. Twenty-three patients underwent a mixed VV+VE procedure. Patency rates were 100%, while functional patency rates were 88.8%. The mean time to patency was 76.9 days. Twelve patients underwent bilateral VEs. Patency was 83.3%, while functional patency was 77.7%. The mean time to patency was 91.5 days. No late failures were identified. The time to either patency definition based upon microscopic fluid evaluation was comparable.

Conclusions: The combination of a tension-relieving hitch for VV and VE and geometric stitch placement demonstrates patency rates among the highest reported in the literature. These technical modifications serve to systematize the procedure to align with the surgical principles of tubular anastomoses through optimal alignment of the lumen, watertight closure, and tension-free connection.

MP 11.4

Surgical and patient-reported outcomes following inguinal and subinguinal urologic procedures under deep intravenous sedation with local anesthesia

Maximilian Fidel[1], Jainik Shah[1], Dhiraj S. Bal[1], Jasmir G. Nayak[2,3], Premal Patel[2,3]
[1]Max Rady College of Medicine, University of Manitoba, Winnipeg, Canada; [2]Men's Health Clinic Manitoba, Winnipeg, Canada; [3]Section of Urology, Department of Surgery, University of Manitoba, Winnipeg, Canada

Introduction: Microscopic denervation of the spermatic cord (MDSC), microscopic varicocelectomy (MSV), and radical orchiectomy (RO) are routinely performed under general (GA) or spinal anesthesia (SA) but are increasingly performed under deep intravenous sedation (DIVS). We sought to investigate the rate of complications and favorable outcomes following MDSC, MSV, and RO performed under DIVS.

Methods: A retrospective study is being performed of patients undergoing: 1) MDSC for chronic and non-resolving orchialgia; 2) MSV for male factor infertility; or 3) RO for a suspected testicular tumor at the Manitoba Men's Health Clinic

MP 11.4. Table 1. Surgical outcome parameters

Procedure type	Mean surgery duration (minutes ± SD)	Mean recovery time (minutes ± SD)	Intraoperative complications (conversion to GA, intolerability, anesthetic issues)
Microscopic denervation of the spermatic cord	39.2±12.7	51.9±26.7	None
Microscopic varicocelectomy	49.1±15.1	44.4±14.7	None
Radical orchiectomy	39.6±17.4	56.5±18.8	None

Mean surgery duration was defined as time of incision to dressing. Mean recovery time was defined as time of entry into post-anesthesia recovery room to leaving the clinic.

(MHC) from October 2022 to December 2023. MHC is an outpatient ambulatory surgical center that accepts patients deemed eligible for day surgery (ASA 1–3). We evaluated intraoperative complications, patient tolerability (assessed at 4–6 weeks), and relevant surgical outcomes postoperatively. Patients were enrolled and consented on the day of the procedure. All procedures were performed under DIVS with local anesthesia using the standard subinguinal approach for MDSC and MSV, and inguinal approach for RO.

Results: Currently, 25 patients with a mean age ± SD of 39.5±14.5 years, 54 patients with a mean age of 35.1±5.2 years, and 25 patients with a mean age of 38.8±14.6 years have undergone a MDSC, MSV, RO procedure, respectively. All procedures were performed successfully, with no conversion to GA. Surgical outcomes are further delineated in Table 1. Postoperatively, 56% of patients reported no pain and 44% of patients reported having improved pain following a MDSC procedure. The mean baseline TMSC was 18.2x106±31.5x106, with the mean postoperative TMSC increasing to 29.2x106±60.9x106 following MSV. All (100%, n=24) patients who have been seen for followup reported tolerating the RO procedure well.

Conclusions: Our preliminary results demonstrate the safety and feasibility of performing MDSC, MSV, and RO under DIVS, with outcomes being comparable to procedures performed under GA or SA.

MP 11.5

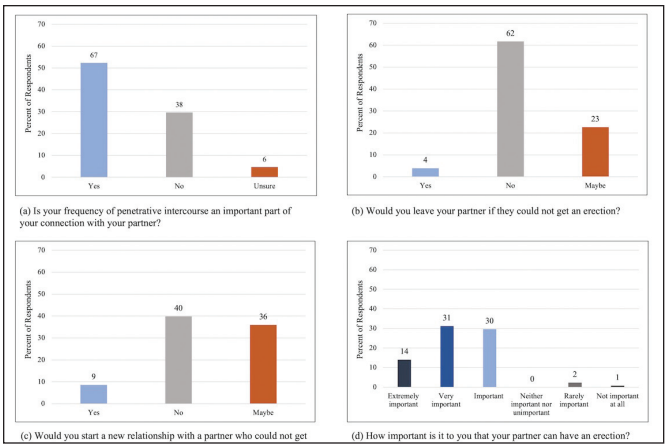
The importance of erectile function in fostering intimacy in heterosexual relationships from the female perspective

Emily Nham[1], Luke Witherspoon[1,2], Ryan K. Flannigan[3], Humberto Vigil[1,2], Lori Brotto[4,5]
[1]Division of Urology, University of Ottawa, Ottawa, Canada; [2]Ottawa Hospital Research Institute, The Ottawa Hospital, Ottawa, Canada; [3]Department of Urologic Sciences, University of British Columbia, Vancouver, Canada; [4]Department of Obstetrics and Gynecology, University of British Columbia, Vancouver, Canada; [5]Female's Health Research Institute, University of British Columbia, Vancouver, Canada;

Introduction: Heterosexual men pursue invasive treatments to maintain erections, yet female views on their significance in healthy relationships remain underexplored. This study examined female perspectives on the importance of erections in relationships.

Methods: A survey-based study employed a virtual 35-item questionnaire adapted from the McCoy Female Sexuality Questionnaire. Participants included heterosexual females aged 18 years and older.

Results: From May to November 2024, 217 survey responses were received, excluding 89 incomplete entries. The average age of participants and their male partners was 33 (SD 11.2) and 35 (SD 10.5) years, respectively. A majority were either married or in long-term relationships (73%). Seventy percent of females considered penetrative intercourse important for their connection with their partners, citing narrative reasons such as partner satisfaction, stress relief, and viewing intercourse as an expression of love, attraction, intimacy, and vulnerability; 37% of females felt that a lack of penetrative intercourse would negatively impact their relationships with narrative concerns around changes in relationship dynamics, male partner masculinity, his mental well-being, and female sexual gratification. Conversely, 26% of females saw penetrative intercourse as non-



MP 11.5. Figure 1. Importance of erections to female partners. Questionnaire responses to 4 questions (a-d) inquiring about how erections factor into sexual heterosexual relationships from the female perspective shown as percentages. Total respondent counts displayed above individual responses.

essential, emphasizing other aspects of intimacy. The majority of females (62%) indicated they would not end a relationship due to a partner's erectile dysfunction (Figure 1). When asked if they would start a relationship with a male with erectile dysfunction, 45% of females said they were open to it, while 40% were not.

Conclusions: Heterosexual females view penetrative intercourse as an important factor in their relationships, alongside other forms of connection and intimacy. The outcomes of our study can help counsel men considering invasive treatments for erections and provide context on the significance women attribute to erections in relationships.

MP 11.6

The use of restorative therapies for erectile dysfunction and Peyronie's disease within Canadian clinics

Jainik Shah[1], Maximilian Fidel[1], Dhiraj S. Bal[1], Yool Ko[1], Connor Roque[1], Premal Patel[2,3]
[1]Max Rady College of Medicine, University of Manitoba, Winnipeg, Canada; [2]Men's Health Clinic Manitoba, Winnipeg, Canada; [3]Section of Urology, Department of Medicine, University of Manitoba, Winnipeg, Canada

Introduction: Restorative therapies (RTs), such as shockwave therapy (Li-SWT) and platelet-rich plasma (PRP), aim to restore natural erectile function without pharmacologic intervention. Many Canadian clinics offer these therapies for conditions including erectile dysfunction (ED) and Peyronie's disease (PD), with direct-to-consumer marketing; however, there is limited data to support their routine clinical use. We sought to investigate the landscape of RTs for ED and PD across Canada.

Methods: Searches were made online to browse for clinics offering Li-SWT and PRP as a RT for ED and PD. Public websites were first analyzed for preliminary information, followed by contacting the clinics to obtain data on treatment cost, protocol, clinic ownership, training of providers, reported success rates, and administration of adjuvant therapies.

Results: This cross-sectional study identified 95 clinics with a 72% response rate (n=68); 53 and 36 clinics provided Li-SWT and PRP, respectively, with 21 clinics offering both. All clinics indicated the use of both RTs for ED, while 21 clinics offered Li-SWT and 22 clinics offered PRP for PD. Forty and 30 clinics provided transparent cost and protocols for Li-SWT and PRP, respectively. The average cost of six sessions of Li-SWT was $2156.67 CAD ($700–4000), and one shot of PRP was $1477.61 CAD ($500–3000). Soxty-one clinics provided information regarding clinic ownership. Of these, 64% (n=39) had a physician onsite, with the majority (n=26) trained in family medicine. Seven did not provide staff credentials and 17 were non-MD trained. Ten clinics provided success rates, with an overall mean success of 87.3%, with one clinic quoting a success rate of 100%.

Conclusions: RTs are being largely marketed directly to consumers, with little urologic intervention prior to treatment. The psychosocial burden faced by patients is only worsened by the substantial financial costs, with non-transparent marketing regarding the limitations and current evidence behind these RT modalities.

MP 11.7

Tolerability of penile plication surgery under varying conscious sedation techniques: A prospective analysis

Dhiraj S. Bal[1], Maximilian Fidel[1], Jainik Shah[1], Matthew Urichuk[1], Premal Patel[2,3]
[1]Max Rady College of Medicine, University of Manitoba, Winnipeg, Canada; [2]Men's Health Clinic Manitoba, Winnipeg, Canada; [3]Section of Urology, Department of Surgery, University of Manitoba, Winnipeg, Canada

Introduction: Penile plication for Peyronie's disease is typically conducted with spinal or general anesthesia (GA) in the hospital setting. Instead, conscious sedation (CS) offers the benefits of lower anesthetic risk, cost-savings, and allows procedures to be conducted in outpatient settings. We sought to compare tolerability under anesthesiologist-administered deep intravenous sedation (DIS) and nursing-administered CS (NACS).

Methods: Between August 2022 and April 2023, adult patients undergoing penile plication were enrolled, excluding revisions and those with hourglass/hinge deformities. DIS included midazolam and ketamine with infusion of propofol and remifentanil. NACS consisted of midazolam and fentanyl. Demographics, procedural variables, and patient- and surgeon-reported pain assessments were collected. Patients were administered a standardized tolerability questionnaire on followup.

Results: Forty patients were enrolled (23 DIS, 17 NACS) with similar demographics. The median preoperative curvature of the DIS cohort was 55° (IQR 43.75–76.25) and 45° (IQR 45–60) in NACS. There was a 100% success rate, with no intraoperative concerns leading to the abortion of the procedure or conversion to GA. On followup, all patients in both cohorts had functional curvature (<20°) and reported they would recommend CS, with similar complication rates (Table 1); 95% (95% CI 75.3–99.0%) of the DIS and 93.3% (95% CI 70.2–98.8%) of the NACS cohort would choose CS over GA for future surgery. Sedation choice did not differ between groups (p=1.0). Most patients reported no pain perioperatively (DIS 16/20, NACS 13/15, p=0.68) or immediately postoperative (DIS 14/20, NACS 14/15, p=0.20).

Conclusions: Penile plication with CS, whether administered by anesthesiologists or nursing staff, is well-tolerated. Patients favor CS over GA for future procedures, experiencing similar pain levels between groups. Outpatient penile plication with nursing-administered CS can safely cut costs, minimize risks, and reduce wait times.

MP 11.7. Table 1. Postoperative complications in DIS and NACS cohorts

Postoperative complications	DIS (%)	NACS (%)
Post-op nausea/vomiting	0 (0 %)	0 (0 %)
Excess pain	3 (14.3%)	0 (0 %)
Infection	1 (4.8%)	0 (0 %)
Hematoma	4 (19.0%)	5 (33.3%)
ER visit	0 (0 %)	0 (0 %)
FM visit	0 (0 %)	0 (0 %)

Absolute number of patients reporting a complication is reported and proportion of the cohort is indicated in parentheses.

MP 11.8

Investigating local anesthesia solely for peno-scrotal surgery: A prospective study on patient comfort and surgical effectiveness without sedation

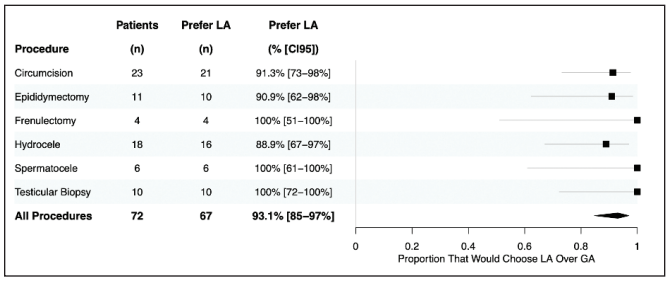
Dhiraj S. Bal[1], Jainik Shah[1], Maximilian Fidel[1], Matthew Urichuk[1], Jasmir G Nayak[2,3], Premal Patel[2,3]
[1]Max Rady College of Medicine, University of Manitoba, Winnipeg, Canada; [2]Men's Health Clinic Manitoba, Winnipeg, Canada; [3]Section of Urology, Department of Surgery, University of Manitoba, Winnipeg, Canada

Introduction: Urologic surgery is typically conducted in hospital settings under spinal or general anesthesia (GA), posing high costs and accessibility challenges. Peno-scrotal surgery, especially, suffers from extended wait times. Our study aimed to assess tolerability and outcomes for peno-scrotal procedures solely under local anesthesia (LA), offering insights into a safer, cost-effective, sedation-free alternative.

Methods: Adult patients undergoing penile or scrotal surgery under LA only were enrolled from August 2022–2023 (NCT05617261). LA was administered along the median raphe with a spermatic cord block or a subcutaneous ring and dorsal penile block. Demographics, surgeon- and patient-reported pain scores, and surgical variables were collected. Patient tolerability to the surgery and future anesthetic choice was assessed on followup as our primary outcome. Complication data, including recurrence (if applicable), emergency room visits, excess pain, hematoma, and infection, was also collected.

Results: A total of 107 patients were enrolled with a mean age ± SD of 42.2±16.4 years. There was a 100% success rate, with no perioperative complications or conversions to sedation or GA. On followup, 93.1% of patients indicated they would opt for LA for a hypothetical repeat procedure, with Figure 1 illustrating this by surgery type. Of the minority opting for GA, most indicated a desire to have no memory of the procedure, highlighting pain is not a limiting factor. On univariate analysis, longer surgeries (0.59, CI 0.20–0.98, p=0.003), cannabis use (1.90, CI 0.40–3.40, p=0.01), and higher intraoperative pain (0.45, CI 0.14–0.77, p=0.005) were associated with lower overall experience.

Conclusions: LA only is promising for peno-scrotal urologic surgery, with high levels of tolerability. With the preservation of good outcomes, we recommend its adoption, as we anticipate significant cost savings with a reduction in patient wait times, surgical and recovery times — allowing for increased surgical efficiency and accessibility.



MP 11.8. Figure 1. Patient preference for future anesthetic by procedure type.

MP 11.9

Fellow mail-in testing platform permits access to post-vasectomy semen analysis: A national demographic analysis

Christopher J. Warren[1], Stacey A. Kenfield[2,3], Civello Daniel[3,4], Dan Nolte[3], James F. Smith[2,3], Nahid Punjani[1], Andre Belarmino[4]
[1]Department of Urology, Mayo Clinic, Phoenix, United States; [2]Departments of Urology, Epidemiology, and Biostatistics, UCSF, San Francisco, United States; [3]Fellow Health, San Leandro, United States; [4]UCLA, Los Angeles, United States

Introduction: Novel mail-in systems have been designed to improve access to semen analysis (SA), especially post-vasectomy semen analysis (PVSA). To date, these have marginally improved access and failed to improve compliance rates. This study evaluated accessibility and reach of a novel mail-in test supplemented by a patient portal and automated reminders.

Methods: Patients undergoing PVSA using the fellow mail-in platform in the

MP 11.9. Table 1. Patient demographics	
Age (years), n (%)	
18–29	629 (10)
30–39	3261 (53)
40–49	1650 (27)
50–59	266 (4.3)
>60	29 (1.1)
Missing	282 (4.6)
Patient region, n (%)	
Northeast	486 (7.9)
Southeast	1190 (19)
Midwest	1424 (23)
Southwest	929 (15)
West	1726 (28)
Missing	362 (5.9)
Driving distance to clinic, n (%)	
<10 miles (16 km)	1469 (24)
11–50 miles (18–80 km)	2859 (47)
51–100 miles (82–161 km)	644 (11)
>100 miles (>161 km)	397 (6.5)
Missing	748 (12)
Household income (USD), n (%)	
<75 000	1146 (19)
75–100 000	988 (16)
100–199 999	2334 (38)
>200 000	1175 (19)
Missing	167 (2.7)
Residential class, n (%)	
Metropolitan	5218 (85)
Non-metropolitan	617 (10)
Missing	282 (4.6)
Education level, n (%)	
High school graduate	1078 (18)
Some college	1504 (25)
College degree or greater	3267 (53)
Patient unsure	24 (0.39)
Missing	244 (4.0)

MP 11.9. Table 1 (cont'd). Patient demographics	
Racial distribution, n (%)	
American Indian/Alaska Native	40 (0.65)
Asian	109 (1.8)
Black or African American	248 (4.1)
Native Hawaiian/Pacific Islander	20 (0.33)
White	5057 (83)
Mixed	196 (3.2)
Patient unsure	178 (2.9)
Missing	269 (4.4)
Insurance status, n (%)	
Medicaid/Tricare	289 (4.7)
Private	5203 (85)
Multiple	82 (1.3)
None	236 (3.9)
Missing	307 (5.0)
Marital status, n (%)	
Married/partnered	5218 (85)
Single	712 (12)
Missing	187 (3.1)

U.S. with a completed demographic survey between August 2021 and October 2023 were included. Data were analyzed by metropolitan status (metropolitan vs. non-metropolitan), clinic region (midwest, northeast, southeast, southwest, or west), driving distances (from patient to clinic), and standard demographics (age, income, education, race/ethnicity, insurance, and marital status). Descriptive statistics of key demographics were reported.

Results: A total of 6117 subjects were included, with an overall kit return rate of 95%. Data are summarized in Table 1 of kit registrants. The mean age was 37.7 years, with 3261 men (53%) between 30–39 years, and 1945 (32%) ≥40 years old. Patients most frequently came from the West (n=1726, 28%). The majority were completed from metropolitan areas (n=5218, 85%); however, >600 men (10%) were from a rural location. Moreover, 754 men (12%) either resided in a non-metro area or attended a clinic in a non-metro area. Most men had a driving distance to clinic of 11–50 miles (18–80 km) but almost 20% drove over 50 miles (82 km), with 7% driving at least >100 miles (161 km). Viability of mail-in PVSA was evident across all demographics, including socioeconomic status, geography, and racial background (Table 1).

Conclusions: Fellow's mail-in system for PVSA, which includes a portal and patient reminders, offers a universal, nationwide strategy for all individuals across racial/ethnic groups, education, income, rural location, partner status, and all geographic regions. These platforms have promise to be expanded to other regions.

MP 11.10

Evaluating the sexual quality of life of urinary stone formers: A multicenter, cross-sectional study

David Bouhadana[1], Liam Murad[2], Ryan Schwartz[3], Sarah Elbaz[4], Lauren Walker[5], Sero Andonian[1], Seth Bechis[6], Vincent Bird[7], Kevin Campbell[7], Ben H. Chew[8], Jonathan Harper[9], Kristina Penniston[10], Roger Sur[6], Necole Streeper[11], Davis Viprakasit[12], Kahina Bensaadi[13], Naeem Bhojani[13]

[1]Division of Urology, McGill University, Montreal, Canada; [2]Faculty of Medicine, McGill University, Montreal, Canada; [3]Faculty of Medicine, Université de Montréal, Montreal, Canada; [4]Faculty of Medicine, Université Laval, Quebec City, Canada; [5]Division of Urology, University of Calgary, Calgary, Canada; [6]Department of Urology, University of California San Diego, California, United States; [7]Department of Urology, University of Florida, Florida, United States; [8]Department of Urologic Science, University of British Columbia, Vancouver, Canada; [9]Department of Urology, University of Washington, Washington, United States; [10]Department of Urology, University of Wisconsin, Wisconsin, United States; [11]Department of Urology, Pennsylvania State University, Pennsylvania, United States; [12]Department of Urology, University of North Carolina , North Carolina, United States; [13]Division of Urology, Université de Montréal, Montreal, Canada

Introduction: The impact of kidney stone disease on quality of life (QoL) was first revealed in the development of the Wisconsin Stone Quality of Life (WisQoL) questionnaire, wherein the maintenance of sexual function and intimacy was a prevalent and important concern. We aimed to identify if patients with more stone disease have a reduced sexual QoL in comparison to those with less stone disease. As a secondary endpoint, we identified predictors of reduced sexual QoL to inform future research and identify characteristics of stone patients who may benefit from sexual counseling.

Methods: A multicenter, cross-sectional study from nine centers across North America was carried out. Patients with a history of urinary stones were recruited. Patients with diagnosed erectile or ejaculatory dysfunction were excluded. Participants filled out four questionnaires, including the WisQoL, Sexual Distress Scale, the Global Measure of Sexual Satisfaction, and either the Male Sexual Health Questionnaire or Sexual Function Questionnaire to evaluate sexual QoL in men and women, respectively. We examined the effect of stone events on reduced sexual QoL.

Results: A total of 169 patients, including 118 men and 51 women, were recruited from nine centers across North America. The mean age of male and female patients was 54 and 51, respectively. The mean number of stone events was nine. Men had moderate erectile (average score of 11/15) and ejaculatory (25/35) function and women had low levels of sexual arousal (3/10) and orgasm (7/15). Among men aged <60, 20% (15/76) and 13% (10/76) reported poor erectile and ejaculatory function, respectively. On average, both men and women had good sexual satisfaction (27/35) and low levels of sexual distress (7/20). There was no significant correlation between the number of stone events and sexual QoL. Age was the only significant predictor of sexual QoL.

Conclusions: This is the first study investigating sexual QoL among kidney stone formers. While both men and women were found to have moderate sexual dysfunction, both had good sexual satisfaction and low levels of sexual distress.

Acknowledgements: This study was supported by the SMSNA Scholars in Sexuality Research Grants Program

MP 11.11

Contemporary outcomes of patients undergoing intralesional verapamil therapy for Peyronie's disease

Kamvir Singh Rai[1], Premal Patel[1,2], Harliv Dhillon[2]

[1]Section of Urology, Department of Surgery , University of Manitoba , Winnipeg, Canada; [2]Men's Health Clinic Manitoba, Winnipeg, Canada

Introduction: Intralesional injection of verapamil has long been used as a non-surgical therapy for Peyronie's disease. Xiaflex became the first FDA- and Health Canada-approved drug for Peyronie's disease, however, it has since been discontinued in Canada. We sought to perform a contemporary evaluation of outcomes for intralesional verapamil.

Methods: A retrospective review of patient records was undertaken for patients undergoing intralesional verapamil at the Men's Health Clinic in Manitoba, Canada, since April 2022. A total of 73 men underwent treatment with intralesional injection of verapamil injection. Records were examined for characteristics of penile curvature, number of injections, restoration of sexual function, and need for subsequent intervention. Descriptive statistics were used.

Results: Seventy-three patients completed treatment with a median age of 58 (range 34–78) years. Most patients (84%) had stable disease, reporting, on average, 7.5 months of stability. Median curvature was 46 (range 10–90) degrees. Overall, 48 (72%), four (6%), 31 (46%), and four (6%), patients reported dorsal, ventral, left, and right components to their curvature, respectively. Firty-seven (81%) patients experienced some degree of penile shortening. On average, patients underwent 5.1 verapamil injections. Of 73 total patients, 64 reported attempting intercourse. Of these, 33 patients (51.6%) were successful and did not proceed to surgical intervention. Of the 31 (48.4%) patients unable to have intercourse, 25 (39.1%) were unsuccessful due to the degree of their curvature, with 18 (28.1%) proceeding with a plication. The remaining six (9.3%) patients were unsuccessful due to erectile dysfunction.

Conclusions: Intralesional verapamil continues to be a cost-effective option for non-surgical management of Peyronie's disease; however, it is important to counsel patients on expectations of therapy.

MP 11.12

Exploring men's health through fertility assessment: Insights from a large population of men using a fellow semen analysis

Luke Witherspoon[1], Stacey A Kenfield[2,3,4], Daniel Nolte[2], Andre Belarmino[2,5], Daniel Civello[2], James F Smith[2,3], Ryan K. Flannigan[6,7], Ali Dergham [1]

[1]Division of Urology, The Ottawa Hospital, Ottawa, Canada; [2]Fellow Health, San Leandro, United States; [3]Department of Urology, University of California San Francisco, San Francisco, United States; [4]Department of Epidemiology & Biostatistics, University of California San Francisco, San Francisco, United States; [5]UCLA Medical Center, Los Angeles, United States; [6]Department of Urologic Sciences, University of British Columbia, Vancouver, Canada; [7]Department of Urology, Weill Cornell Medicine, New York, United States

Introduction: Infertile males have been found to have a greater number of medical comorbidities (PMH) compared to fertile controls. In this study, we sought to investigate the PMH associated with the reason for undergoing a semen analysis (SA).

Methods: Men obtaining SA through Fellow were included under an IRB-approved protocol. Subjects were included if they were ≥18 years old and completed a survey reporting their PMH. The association between PMH and reason for obtaining a SA was investigated. Chi-squared tests, Fisher exact tests, and logistic regression models were used to determine statistical significance ($p<0.05$).

Results: A total of 7273 patients were included from April 2021 to December 2023. The most prevalent medical factors included high BMI (25 kg/m2, 74.6%, n=5424), advanced paternal age (40 years, 28.4%, n=2066), depression (10.1%, n=734), hypertension (9.4%, n=682), and hyperlipidemia (6.4%, n=463). The proportion of patients reporting any medical comorbidities by reason for ordering a kit were as follows: vasectomy or vas reversal (30.2%), family planning (31.4%), difficulty conceiving (30.7%), being curious (39.6%), and other or multiple reasons (34%) ($p=0.034$). PMH most strongly ($p<0.01$) associated with the reason for SA included: advanced paternal age, high BMI, cancer, epididymitis, and testicular injury. Compared to the vasectomy group, those trying to conceive for >12 months had 24% higher odds of reporting a medical condition (OR 1.24, $p=0.02$) and the curious group had 62% higher odds of reporting a medical condition (OR 1.62, $p<0.001$) after adjustment for age.

Conclusions: The proportion of patients reporting any medical comorbidities varied by reason for conducting a SA. On average, 30–40% of all men seeking to evaluate their fertility with a Fellow SA had a significant medical comorbidity. The fertility evaluation is a prime time for physicians to identify other key health concerns in their patients.

MP 11.13

Efficacy of EMLA cream-assisted loco-sedation for office-based andrology procedure: A randomized controlled study

David Taekhwan Chung[1], Dhiraj S. Bal[2], Maximilian Fidel[2], Jainik Shah[2], Harliv Dhillon[3], Hesma Van Heerden[3], Connor Roque[2], Jasmir G. Nayak[1], Premal Patel[1]
[1]Section of Urology, University of Manitoba, Winnipeg, Canada; [2]Max Rady College of Medicine, University of Manitoba, Winnipeg, Canada; [3]Men's Health Clinic, Winnipeg, Canada

Introduction: There has been an increasing number of office-based urology procedures performed under local anesthesia (LA), although it can be associated with needle phobia and pain. Eutectic mixture of local anesthetic (EMLA) is a topical anesthetic cream that is used in office-based urology procedures; however, its use in more involved/invasive andrology and male infertility procedures, such as hydrocelectomy, penile plications, and others, remains poorly studied. We hypothesize that pre-application of EMLA cream in office-based andrology and male infertility procedures may provide better pain control and overall experience for patients.

Methods: A single-blinded, randomized controlled trial was conducted for patients undergoing scrotal andrology and male infertility surgeries under LA. Power calculation was performed with an estimated sample size of 72. Participants were randomly assigned in a 1:1 ratio to topical EMLA + LA vs. LA alone. In the postoperative recovery area, patients were asked to complete a VAS questionnaire rating pain with LA administration and pain with procedure. Analysis comparing VAS pain scores of both groups was performed using the independent sample t-test method. Full recruitment is expected by March 2024.

Results: Thus far, 62/72 patients have been recruited, with 31 in the control and 31 in the intervention arm. For patient pain with administration of LA, the control arm reported an average VAS pain score of 4.34 compared to 3.87 in the control arm (p=0.453). For patient pain with procedure, patients in the control arm reported a median VAS pain score of 3.79 compared to 3.23 in the intervention arm (p=0.406). No significant differences were seen in VAS pain scores for intervention and control arms. Overall, 83% (52/62) of patients reported that they would either be "very likely" or "highly likely" to undergo future procedures under LA.

Conclusions: Performing scrotal andrology and male infertility surgeries under LA appears to be a well-tolerated and feasible option. It remains to be seen if pre-application of EMLA significantly reduces pain with LA administration and procedure. Study completion is expected by March 2024.

MP 11.14

Advanced paternal age (40 years) and diabetes are associated with low semen volume in a nationwide cohort of men obtaining a fellow semen analysis

Luke Witherspoon[1], Stacey F Kenfield[2,3,4], Daniel Nolte[2], Andre Belarmino[2,5], Daniel Civello[2], James F Smith[2,3], Ryan K. Flannigan[6,7], Ali Dergham [1]
[1]Division of Urology, The Ottawa Hospital, Ottawa, Canada; [2]Fellow Health, San Leandro, United States; [3]Department of Urology, University of California San Francisco, San Francisco, United States; [4]Department of Epidemiology & Biostatistics, University of California San Francisco, San Francisco, United States; [5]UCLA medical Center, Los Angeles, United States; [6]Department of Urologic Sciences, University of British Columbia, Vancouver, Canada; [7]Department of Urology, Weill Cornell Medicine, New York, United States

Introduction: Semen quality has been previously described as a window into male health, with higher rates of medical comorbidities among males with abnormal semen analyses. In this study, we sought to investigate medical comorbidities associated with low semen volume.

Methods: Males performing semen analyses through Fellow Health were assessed under an IRB-approved protocol. Inclusion criteria included males 18 years of age and older with valid semen samples who completed a survey reporting medical comorbidities. Exclusion criteria included: vasectomy, cystectomy, prostatectomy, and spinal cord injury. Chi-squared tests, Fisher exact tests, and logistic regression models were used to determine statistical significance, with a p=0.1 significance level.

Results: A total of 1868 patients were included from June 2022 to October 2023; 121 (6.5%) of 1868 patients were found to have low semen volume (<1.4 cc). Of those aged 40+ years, 9.8% had low volume compared with 5.7% of those aged <40 years (p=0.006). Less than half (40.5%) of patients reported a health condition in the low semen volume group vs. 31.7% in the normal semen volume group (p=0.06). Other conditions with N≥10 that were associated with low vs. normal semen volume included diabetes (10.7% vs. 2.3%, p<0.0001) and hypertension (14.9% vs. 9.4%, p=0.07). In logistic regression analyses adjusted for age, the associations of low vs. normal semen volume persisted when estimating the odds of any medical condition (OR 1.41, p=0.07) and diabetes (OR 4.53, p<0.0001) but did not persist for hypertension (OR 1.46, p=0.17).

Conclusions: Advanced paternal age 40+ and diabetes mellitus are associated with low semen volume (p<0.05). This information is important for counselling prospective patients being evaluated for infertility. Individuals with low semen volume have 4.5 times greater odds of having diabetes; therefore, a detailed history and exam should be elicited to identify risk factors for diabetes and potential investigational screening.

MP 11.15

Inflatable penile prosthesis implantation in the outpatient setting: Surgical and patient-reported outcomes

Maximilian Fidel[1], Jainik Shah[1], Dhiraj S. Bal[1], Jasmir G. Nayak[2,3], Premal Patel[2,3]
[1]Max Rady College of Medicine, University of Manitoba, Winnipeg, Canada; [2]Men's Health Clinic Manitoba, Winnipeg, Canada; [3]Section of Urology, Department of Surgery, University of Manitoba, Winnipeg, Canada

Introduction: Inflatable penile prosthesis (IPP) insertion is increasingly performed as a same-day outpatient procedure compared to the traditional hospital approach with overnight stay. We sought to investigate the outcomes and rate of complications among patients within six weeks of their IPP insertion in the outpatient setting.

Methods: A mixed-methods study has been performed since February 2023 of all patients undergoing day surgery insertion of an IPP at Manitoba Men's Health Clinic (MHC), an outpatient ambulatory surgical center accommodating patients classified as ASA 1–3 for day surgery. Patients were prescribed trimethoprim/sulfamethoxazole BID two days before surgery, along with a dexedin/hibiclens wash. Vancomycin and gentamycin were given preoperatively. Intraoperative irrisept wash was used during the case for irrigation and implant preparation. All procedures involved a three-piece prosthetic device and were performed under spinal anesthesia or deep intravenous sedation with local anesthesia, via an infrapubic approach. Postoperatively, gabapentin, celecoxib, and acetaminophen were given for analgesia.

Results: Currently, 41 patients are enrolled, with a mean patient age ± SD of 61.4±9.1 years. All procedures were performed successfully, with no intraoperative complications. The mean procedure length, defined as time from incision to time of dressing, was 65.5±18.7 minutes. The mean postoperative duration of stay, defined as patient entry into the postoperative recovery room to time they left the clinic, was 121.7± 62.5 minutes. Patients were cleared to use the device after six weeks. One patient has required an emergency room visit. No patients experienced infection or hospital admission; 7.3% of the patients required additional prescriptions for postoperative analgesia.

Conclusions: Our preliminary results demonstrate the safety and feasibility of performing an IPP in the outpatient setting, with similar rates of complications in existing literature.

MP 11.16

What's around the bend? Sutureless Peyronie's graft

Darby James Cassidy[1]
[1]Men's Health, Bettermale Clinic, Prince George, Canada

Introduction: The gold standard for the management for clinically significant Peyronie's disease continues to be surgical correction; however, surgical correction, particularly of severe or complex Peyronie's disease, remains a challenging problem for most urologic surgeons. Severe or complex deformities include curvatures >60 degrees, significant penile shortening, hourglass deformities, and plaques associated with a hinge effect. In these cases, plaque excision and grafting procedures are recommended for those with good preoperative erectile function. This poster describes the use of a sutureless graft using 'Hemopatch,' a collagen fleece hemostatic patch that simplifies the procedure without compromising surgical outcomes in early analysis.

Methods: Four men with severe Peyronie's disease underwent surgical correction by a single surgeon. The procedure itself is done identically to the standard plaque excision and grafting, as previously described in the literature until it comes to securing the graft. The Hemopatch graft is simply applied to the

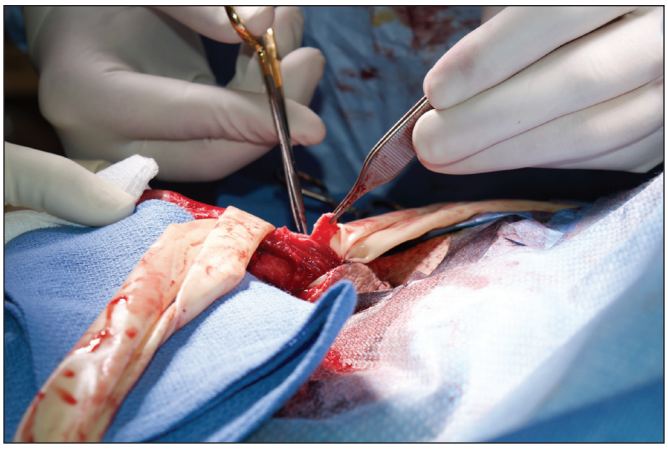
corporal defect ensuring a 1 cm overlap beyond the defect margins, and held in place for two minutes without the need for precise measuring. The patch is activated by contact with blood and body fluids or accelerated by the use of a sodium bicarbonate-soaked sponge. This allows for adhesion and creation of a watertight seal without the need for any sutures.

Results: The average OR time was 72 minutes faster than for previous surgeries using sutured grafts. After a minimum of three months followup, there was no change in preoperative IIEF-5 or EHS scores. There was significant resolution of penile curvature, allowing for easy and comfortable penetration and sexual intercourse in all men. The average increase in erect penile length was 2 cm postoperatively.

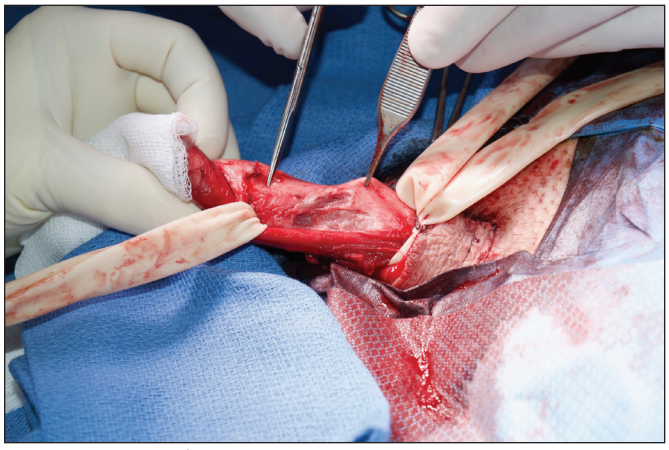
Conclusions: In men with severe Peyronie's disease, using a sutureless graft with 'Hemopatch,' a collagen fleece hemostatic patch, simplifies the procedure without compromising surgical outcomes in early analysis. Longer-term followup is needed to ensure the robustness of these findings.

References:

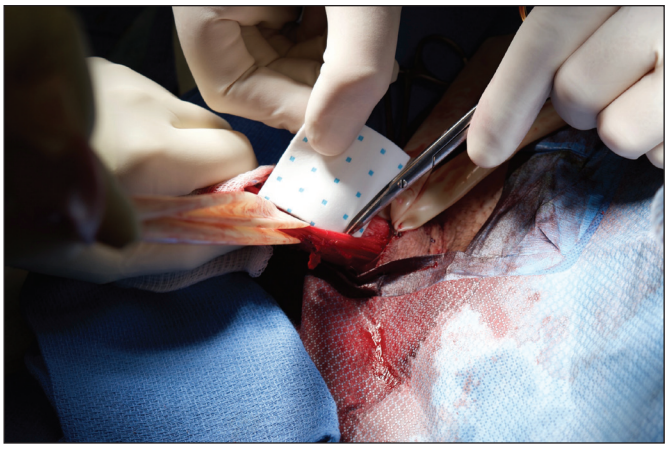
1. Schwarzer U, Sommer F, Klotz T, et al. The prevalence of Peyronie's disease: Results of a large survey. *BJU Int* 2001;88:727-30. https://doi.org/10.1046/j.1464-4096.2001.02436.x.
2. Mulhall JP, Creech SD, Boorjian SA, et al. Subjective and objective analysis of the prevalence of Peyronie's disease in a population of men presenting for prostate cancer screening. *J Urol* 2004;171(6Pt1):2350-3.https://doi.org/10.1097/01.ju.0000127744.18878.f1
3. Stuntz M, Perlaky A, des Vignes F, et al. The prevalence of Peyronie's disease in the United States: A population-based study. *PLoS One* 2016;11:e0150157. https://doi.org/10.1371/journal.pone.0150157
4. Hatzichristodoulou G, Tsambarlis P, Kübler H, et al. Peyronie's graft surgery - tips and tricks from the masters in andrologic surgery. *Transl Androl Urol* 2017;6:645-56. https://doi.org/10.21037/tau.2017.07.17
5. Baldini A, Morel-Journel N, Paparel P, et al. Patient-reported long-term sexual outcomes following plication surgery for penile curvature: A retrospective 58-patient study. *Prog Urol* 2017;27:10-6. https://doi.org/10.1016/j.purol.2016.08.018
6. Wimpissinger F, Parnham A, Gutjahr G, et al. 10 years' plaque incision and vein grafting for Peyronie's disease: Does time matter? *J Sex Med* 2016;13:120-8. https://doi.org/10.1016/j.jsxm.2015.12.004
7. Falcone M, Preto M, Ceruti C, et al. A comparative study between 2 different grafts used as patches after plaque incision and inflatable penile prosthesis implantation for end-stage Peyronie's disease. *J Sex Med* 2018;15:1061-2. https://doi.org/10.1016/j.jsxm.2018.04.632
8. Rosenhammer B, Sayedahmed K, Fritsche HM, et al. Long-term outcome after grafting with small intestinal submucosa and collagen fleece in patients with Peyronie's disease: A matched pair analysis. *Int J Impot Res* 2019;31:256-62. https://doi.org/10.1038/s41443-018-0071-1
9. Carrino M, Chiacone F, Langella N, et al. Single institution experience with «penile patches» in patients with Peyronie's dsease and erectile dysfunction. Abstracts XXVII Congresso Nazionale AURO.it digitale. 17-19 September 2020. https://doi.org/10.1016/j.jsxm.2020.07.054



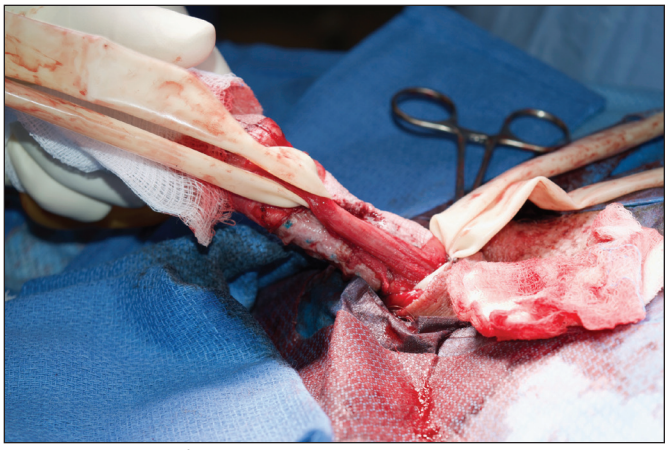
MP 11.16. Figure 1. Graft 1.



MP 11.16. Figure 2. Graft 2.



MP 11.16. Figure 3. Graft 3.



MP 11.16. Figure 4. Graft 4.

MP 11.16. Figure 5. Graft 5.

MP 11.17

Fractional CO_2 laser for the treatment of Peyronie's disease: A pilot clinical trial

Justin Y.H. Chan[1], *Abdulla Alhamam* [2,3], *Luke Witherspoon*[4,5], *Jason K. Rivers*[6,7], *Ryan K. Flannigan*[8,9]

[1]Division of Urology, Department of Surgery, University of Toronto, Toronto, Canada; [2]Department of Urology, Imam Abdulrahman Bin Faisal University, Dammam, Saudi Arabia; [3]Department of Urology, Imam Abdulrahman Bin Faisal University , Dammam, Saudi Arabia; [4]Division of Urology and Men's Health Centre, The Ottawa Hospital, Civic Campus, Ottawa, Canada; [5]Division of Urology and Men's Health Centre, The Ottawa Hospital, Civic Campus, Ottawa, Canada; [6]Department of Dermatology and Skin Science, University of British Columbia, Vancouver, Canada; [7]Department of Dermatology and Skin Science, University of British Columbia, Vancouver, Canada; [8]Department of Urologic Sciences, University of British Columbia, Vancouver, Canada; [9]Department of Urologic Sciences, University of British Columbia, Vancouver, Canada

Introduction: Peyronie's disease (PD) is a fibrosing disorder of the penis that may result in penile curvature and deformity of the erect penis. Consequently, afflicted males may experience significant sexual dysfunction and psychological distress. Fractional CO2 laser therapy may serve as a novel minimally invasive treatment for PD, as it is an intervention to treat similar fibrosing conditions such as Dupuytren's contractures. The objectives of the study were to evaluate changes in penile curvature and the safety of fractional CO2 laser therapy in subjects with chronic phase PD.

Methods: This was a single-site, non-randomized, open-label study using a fractional CO2 laser. Subjects underwent three treatment sessions every six weeks with a fractional CO2 device using low-density settings. Topical triamcinolone (10 mg/cc) was applied immediately after each treatment. Between treatments, patients were required to perform at-home penile modeling three times daily. Penile curvature assessments, as measured by iatrogenic tumescence, ultrasound measurements, and self-reported questionnaires were collected at baseline, 24-week, and 52-week followups. Adverse events were assessed at each treatment and by self-reported diaries.

Results: Five patients were included in the study and completed all the followup assessments. The median baseline penile curvature was 37° (range 30°–50°) and at 52 weeks, this had reduced to a median curvature of 28° (range 14°–44°) (p=0.03). This represented a median reduction in penile curvature by 24.3% (range 16.9–53.3%) and a mean change of -11.6°±3.58° in curvature for each patient. Overall, the International Index of Erectile Function-5 Questionnaire overall scores were comparable at baseline and at 52-week followup (median 59, range 33–71 vs. median 60, range 52–72, respectively, p=0.81); however, patients did report significant improvement in overall Peyronie's disease questionnaire scores from baseline to 52 weeks after laser treatment (median 26, range 15–30 vs. median 14, range 6–23, respectively, p=0.03). Four patients reported either mild penile bruising, skin scaling, or pruritus immediately after laser therapy that resolved spontaneously within two weeks.

Conclusions: Fractional CO2 laser therapy may serve as a well-tolerated and minimally invasive therapy for PD, with results at both 24 and 52 weeks being encouraging. Further studies are warranted to evaluate the safety and efficacy of fractional CO2 laser therapy in the treatment of PD.

MP 11.18

Prostate cancer survivorship: Cross-sectional analysis of patient-reported experience following diagnosis or treatment of prostate cancer

Thomas Michael Southall[1], *Premal Patel*[1]

[1]Section of Urology, Department of Surgery, University of Manitoba, Winnipeg, Canada

Introduction: Prostate cancer impacts patient lives beyond oncologic concerns alone. This includes mental, physical, sexual, emotional, and financial effects that continue throughout life. We aim to determine survivor experiences from both an oncologic and functional perspective throughout survivorship.

Methods: This is a prospective, cross-sectional survey of survivors. Our survey was circulated to all members of the Manitoba Prostate Cancer Support Group. Topics included erectile dysfunction, penile shortening, urinary incontinence, and patient understanding throughout their care. Survey items included binary and Likert scale questions regarding patient understanding and treatment impact, as well as an open-ended question asking how survivorship care may be improved.

Results: A total of 514 patients received our survey and 122 patients responded for a response rate of 23.7%. The average ages of diagnosis and treatment were 65.2 and 65.9, respectively. The most common treatments included 63.9% radical prostatectomy, 54.1% radiotherapy, and 36.1% androgen deprivation therapy. Most (71.9%) reported sexual health to be very or somewhat important, but 27% reported no pre-treatment discussion of potential erectile dysfunction. A lack of understanding of treatment impact on erections was reported by 14.9%, while 76.9% reported no counselling on penile shortening and 95% reported no counselling on climacturia prior to treatment. Regarding urinary incontinence, 27.3% reported no pre-treatment discussion; only 12.3% reported lacking understanding of treatment impact on urination. Post-treatment, 65.7% reported physician-led counselling for sexual dysfunction and 23.5% of patients reported treatment decision regret. Common open-answer responses included a desire for more information regarding support groups, treatment side effects, and their management.

Conclusions: Counselling patients about treatment options must include discussion of treatment side effects, as well as treatment for such. Many patients expressed poor understanding of treatment impact on urination and sexual function. Patients were motivated to learn about their condition, requesting more information on treatments, side effects, and local support groups.