



EAU19 | BARCELONA
15-19 March 2019
Cutting-edge Science at Europe's largest Urology Congress

EAU 2019: Pediatrik Üroloji

Dr.Kubilay Sabuncu

Bursa Karacabey Devlet Hastanesi



Pediatric Üroloji Oturumları

- 15 oturumda pediatrik ürolojiyle ilgili sunumlar yapıldı.
- 2 adet ESU kursu
- 1 Urology beyond Europe
- 1 Abstract video session
- 2 Section meeting (EULIS, ESGURS)
- 5 Abstract poster session
- 1 Thematic session
- 1 Abstract Expert-Guided poster tour

- Toplam 98 sunum yapıldı.
- Türkiye'den 8 sunum mevcuttu.

Young Academic Urologists Awards

Best paper by YAU in 2018

Late ascended testes: is non-orthotopic gubernacular insertion a confirmation of an alternative embryological etiology?

J Pediatr Urol. 2018 Oct 25. pii: S1477-5131(18)30630-2. doi:10.1016/j.jpuro.2018.10.013

B. Haid, S. Silay, A. Radford, P. Rein, B. Banuelos, J. Oswald, A. Spinoit (Linz, Austria; Istanbul, Turkey; Leeds, United Kingdom; Berlin, Germany; Gent, Belgium)

Best abstract by YAU in EAU19

Evaluation of surgical outcome of SWL, mini-PCNL and RIRS for the management of lower pole stones with a size of <2cm stones: A systematic review and meta-analysis
Abstract 4333

P. Kallidonis, D. Kotsiris, C. Adamou, P. Ntasiotis, B. Somani, T. Tailly, M. Oszoy, E. Liatsikos (Patras, Greece; Southampton, United Kingdom; Gent, Belgium; Vienna, Austria)

Best reviewer YAU

Reviewer and associate editor of Journal of Sexual Medicine

F. Castiglione, London, United Kingdom

Fri 15 March
09:45 - 12:15

Location:

Green Area, Room 17

Chairs:

 C.C.M. Lei, Kuching (MY)
 J. Rassweiler, Heilbronn (DE)

Aims and objectives of this session

This session continues the excellent collaboration between the major countries included in the FAUA and the EAU. Focusing on four important fields in urology, experts from Asia and Europe will present and discuss new developments. There will be a special focus on the Discussion with active participation of the delegates.

09:45 - 09:50

Welcome and introduction
 C.C.M. Lei, Kuching (MY)

09:50 - 10:30

Paediatric urology

09:50 - 10:00

DSD, Development Sexual Dysfunction
 I. Wahyudi, Jakarta (ID)

10:00 - 10:10

Hypospadias in Indonesia
 G.W.K. Duarsa, Denpasar (ID)

10:10 - 10:20

Diagnosis and treatment of testicular torsion: A multicenter clinical study in Thailand
 P. Mahawong, Chiang Mai (TH)

10:20 - 10:30

How to avoid complications of circumcision
 G. Bogaert, Leuven (BE)

Checklist assessment tool to evaluate suitability and success of neonatal clamp circumcision: A prospective study

Charles W. Concodora^a, Max Maizels^b, Gregory E. Dean^a,
Dana A. Weiss^c, Seth A. Alpert^d, John D. Edmondson^e,
Jack S. Elder^f, Anthony Herndon^g, James M. Elmore^h,
Karen Rychlik^b

MEDICAL CLEARANCE	
Weight is greater than 5lbs?	☐ YES ☐ NO
No history of bleeding diathesis? (includes infant and family)	☐ YES ☐ NO
No history of congenital heart disease?	☐ YES ☐ NO
No history of G-E Reflux?	☐ YES ☐ NO

EXAM AT BEDSIDE	
(Exam may be benefited by applying gentle downward manual pressure at base of penis, so as to induce a mild erection)	
PENILE SHAFT	
Normal length? (greater than 3cm)	☐ YES ☐ NO
Straight with less than 30 degrees of penile curvature? (No presence of chordee)	☐ YES ☐ NO
Less than 45 degrees of counter-clockwise penile torsion?	☐ YES ☐ NO
GLANS CORONA	
The corona ridge is evident? (Provides a landmark for the use a marking pen)	☐ YES ☐ NO
SKIN SURFACES	
Prepuce-meatus is circumferential? (No presence of a dorsal hood, partial natural circ.)	☐ YES ☐ NO
Is the penopubic crease normal?	☐ YES ☐ NO
Is the penoscrotal junction normal?	☐ YES ☐ NO
PENIS MEDIAN RAPHE	
Median raphe is straight along the entire shaft and foreskin? (If "NO", you may proceed but with heightened awareness for possible hypospadias variant when the foreskin is retracted)	☐ YES ☐ NO

If the responses to ALL the above checkpoints are "YES" then clamp circumcision is suitable, otherwise stop and request a Pediatric Urology consultation.

EXAM AFTER RETRACTION OF PREPUCE	
URETHRA MEATUS POSITION	
Is the urethra meatus on the glans?	☐ YES ☐ NO
GLANS	
Is the glans size normal?	☐ YES ☐ NO
Is the glans still straight after retraction of prepuce?	☐ YES ☐ NO

If the responses to the ALL the above checkpoints are "YES" then it is suitable to complete clamp circumcision, otherwise stop and request a Pediatric Urology consultation.

(Perform at about 10 days after circumcision)

CIRCUMCISION SITE	
Located below the corona	☐ YES ☐ NO
Circumcision site parallels the corona	☐ YES ☐ NO
SKIN SURFACES	
Penoscrotal site normal	☐ YES ☐ NO
GLANS	
Normal urethra meatus	☐ YES ☐ NO

If the responses to ALL the above checkpoints are "YES" then the circumcision is considered a success.

Figure 2 "Checklist Assessment for Successful Circumcision". A checklist to assess for post-circumcision outcomes.

Simulation models

eNasco



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QUOTE



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A New Simulation Model for Teaching Neonatal Circumcision.

G Saleh, N Angell, R Goldman, W Ho, N Morin

Figure 1

Table 1

Materials

1. 2 small balloons
2. 1 scissor
3. 1 hemostat (not shown)
4. 1 probe
5. aluminum foil (2.5" x 1.5" piece)
6. saline tie (-12")
7. surgical tape, 3-5mm thickness (3.5" x 2.5" piece)
8. ultrasound gel (bottle with spoon)



BUILDING THE MODEL

Figure 2

1. Cut a 2-3 mm hole in the outer balloon



Figure 3

2. Place the outer balloon over the inner balloon using the probe



Figure 4

3. Fill the inner balloon with ultrasound gel to the desired size and turgor and squeeze out any air bubbles



Figure 5

4. Use the hemostat to occlude the neck of the balloons



- **If you are a doctor or a urologist :
do not “convince” for circumcision (except...)**
- **Respect the culture of your patient**
- **Make sure you can do it safe and do not harm**

Restore (fore)skin



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V11

Simultaneous bilateral endoscopic surgery (SBES): A new technique for the treatment of bilateral renal stones

By: Proietti S.¹, Rodriguez Socarras M.E.¹, Eisner B.², Saitta G.¹, De Coninck V.¹, Mantica G.¹, De Marchi D.¹, Bellinzoni P.¹, Gaboardi F.¹, Giusti G.¹

Institutes: ¹San Raffaele Hospital, Ville Turro Division, Dept. of Urology, Milan, Italy, ²Harvard Medical School, Massachusetts General Hospital, Dept. of Urology, Boston, United States of America

 **Abstract**

 **Video**

 **Webcast**

[Aims and objectives of this presentation](#)

V11

V12

The management of urinary stones in pediatrics: Overcoming traditional challenges with Moses technology

By: Tasian G.

Institutes: The Children's Hospital of Philadelphia, Dept. of Urology, Philadelphia, United States of America

 **Abstract**

 **Video**

 **Webcast**

[Aims and objectives of this presentation](#)

V12

V13

High-power holmium laser with Moses technology: Our initial experience

By: Angerri Feu O., Sabiote L., Mayordomo O., Mosquera L., Flores L.D., Emiliani E., Kanashiro A., Sánchez-Martín F., Millán F., Palou J.

Institutes: Fundació Puigvert, Dept. of Urology, Barcelona, Spain

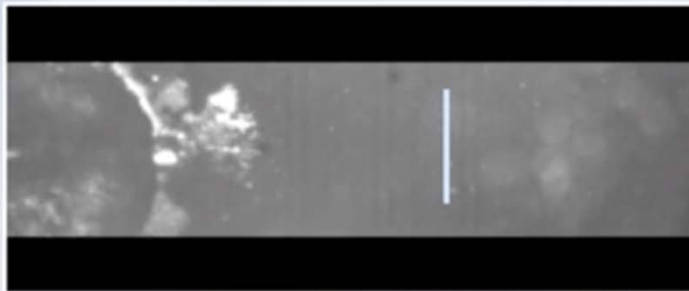
 **Abstract**

 **Video**

 **Webcast**

The MOSES Technology

Regular



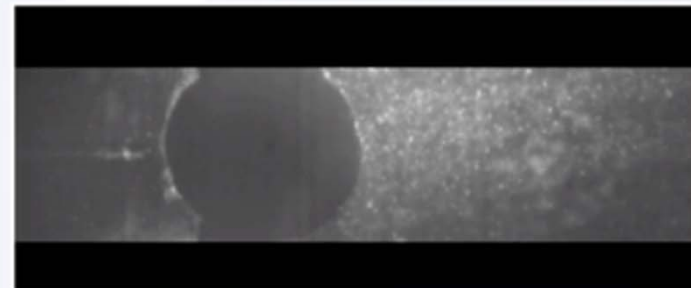
3.5J / 20Hz



MOSES



3.5J / 20Hz



Surgical treatment of urinary tract stones in children require special considerations and provide additional challenges compared to adults:

- Limit anesthetics (duration of operation and number of surgeries).
- Reduce morbidity from ureteral stents (e.g. decrease need for pre-stenting).
- Navigate smaller kidneys with more acute infundibular angles.

High-powered lasers with MOSES technology may offer benefits for pediatric patients.

The objective of this evaluation was to describe the initial experience with a high-powered laser with MOSES technology in pediatric patients with urinary tract stones.

Demographics

No. of patients	8		
Age	Average: 17 years old [10- 32]		
Gender	Female - 50% [4]	Male - 50% [4]	
History	Newly diagnosed – 50% [4]	Recurrent – 50% [4]	

Case Info

Stone location	Kidney- 50% [4]	Ureter- 12.5% [1]	Kidney & Ureteral- 37.5% [3]
Total no. of stones	Average: 3.75 [1-8]		
Accumulated stone volume [mm]	Average: 14.5 [4-35]		

Tools & Techniques

System	Lumenis MOSES Pulse 120H	
Fiber	Moses 200 D/F/L in all cases	Moses 365 D/F/L was also used in 1 case
Scope	Flexible scope was used in all cases (Storz Flex-Xc digital or Storz Flex-X ²)	Semirigid scopes were also used in 4/8 cases (Wolf 4.5Fr "Needle")
Laser settings	0.2- 1 J, 15- 80 Hz	Moses contact was utilized in all cases Moses distance was tested in 5/8 cases
Retrieval	Basket was used in all cases [8/8]	
Stenting	Pre-stenting is not done routinely (pending ureteral accessibility)	
Access sheath	Rarely used (only in special cases when multiple fragments need to be basketed)	

Immediate outcomes:

- After ureteroscopy, a stent on a string is usually placed.
- Stent is removed by the patient at home 5-7 days after surgery.
- All patients who underwent ureteroscopy were released from the hospital the same day.
- One patient, who underwent complicated PCNL in combination with antegrade URS, was hospitalized for 3 days due to underlying pulmonary disease.

Follow-ups:

- Stone clearance is routinely defined by renal ultrasound at 4-6 weeks post operatively.
- CT is not perform in children to determine SFR.
- Follow-up pathway results are still in process for this cohort of patients.

Conclusions:

- This is one of the first reports demonstrating the usage of MOSES technology for pediatric population.
- MOSES LP120H system and fibers show different potential advantages:
 - High speed dusting may reduce the need for access sheath.
 - High power system and effective stone clearance may reduce the need for stenting.
 - Flexible and durable 200 ball tip fibers allows access to hard to reach location - avoiding re-operations and staged procedures, including pre-stenting.
 - MOSES technology leading to minimal retropulsion and thus reducing stone migration and dislodgment to other organs.
 - Controlled “popcorning”. Working in small calyces together with the MOSES technology allows effective popcorning of stone fragments.
 - Decreased operative time.

Laparoscopic and robotic-assisted repair of retrocaval ureter in children: A multi-institutional comparative study with open repair

Esposito C.¹, Masieri L.², Valla J.³, Lopez P.J.⁴, Tokar B.⁵, Mushtaq I.⁶, Sforza S.⁷, Venturini S.⁷, Escolino M.¹

1 Federico II University of Naples, Dept. of Pediatric Surgery, Naples, Italy, 2 University of Florence, Dept. of Urology, Florence, Italy, 3 CHU Laval, Dept. of Pediatric Urology, Nice, France, 4 Hospital Exequiel Gonzalez Cortes & Clinica Alemana, Dept. of Pediatric Urology, Santiago, Chile, 5 Eskisehir Osmangazi University, Dept. of Pediatric Urology, Eskisehir, Turkey, 6 Great Ormond Street Hospital, Dept. of Pediatric Urology, London, United Kingdom, 7 University of Florence, Dept. of Urology, Florence, Italy

- Toplam 12 hasta
- 3 grup: G1 (laparoskopik) n=5, G2 (robotik) n=4, G3 (açık) n=3
- Tüm hastalarda semptomlar tamamen düzelmiş.
- 1. gruptan 1 hasta tekrar opere edilmiş.
- Hiçbir hastada komplikasyon gelişmemiş.

- Operasyon süreleri G1:178dk, G2:135dk, G3:210dk
- Grup 1 ve 2 operasyon sonrası analjezik kullanımı, hastanede kalış süresi ve kozmetik açıdan avantajlı.
- Minimal invaziv cerrahi retrokaval üreter onarımında ilk tercih olmalıdır.

Robot-assisted laparoscopic pyeloplasty (RALP) in children with horseshoe kidneys: results of a multicentric study

Esposito C.¹ · Masieri L.² · Blanc T.³ · Manzoni G.⁴ · Silay S.⁵ · Cerulo M.¹ · Venturini S.² · Escolino M.¹

¹ Division of Pediatric Urology, Federico II University of Naples,, Naples, Italy ² Division of Pediatric Urology, Meyer Children Hospital, Florence, Italy ³ Division of Pediatric Urology, Hôpital Necker-Enfants Malades, Paris, France ⁴ Division of Pediatric Urology, Ospedale Maggiore Policlinico, Milan, Italy ⁵ Division of Pediatric Urology, Istanbul Medeniyet University, Istanbul, Turkey

- 14 at nalı böbrek deformiteli çocuk
- Docking dahil ortalama süre 143dk
- Hiçbir hastada laparoskopiyle devam edilmemiş veya açık operasyona geçilmemiş.
- d-J kateter ortalama 33. günde çekilmiş.
- Başarı oranı %92.8

- At nalı böbrekli pediatrik hastalarda robotik onarım güvenli ve uygulanabilir.
- Orta-dönem sonuçları iyi.
- Robotik cerrahi, minimal invaziv cerrahide laparoskopinin teknik zorlukları olmadan avantajlarını sunan bir tekniktir.

Ureterocele size predicts surgical management and outcome: data from 20 years experience with long follow-up

Bernhard Haid^{*,§}, Mona Kerling^{*}, Regina FJ Stredle^{*}, Josef Oswald[§], Raphaela Waidelich^{*} and Marcus Riccabona^{*}

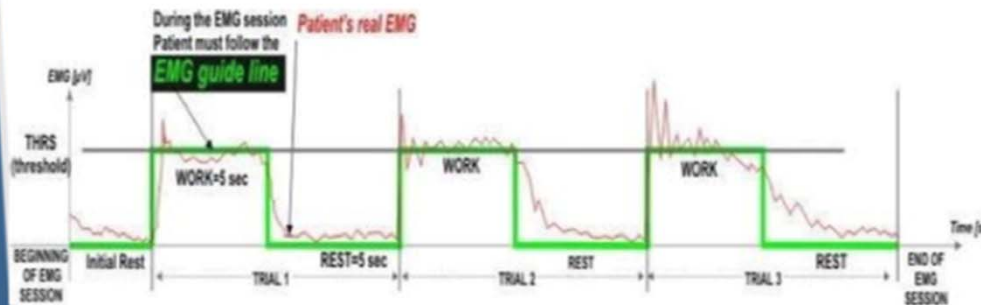
^{*} Department of Urology, Ludwig-Maximilians University, Munich, Germany

[§]Department of Pediatric Urology, Hospital of the Sisters of Charity, Linz, Austria

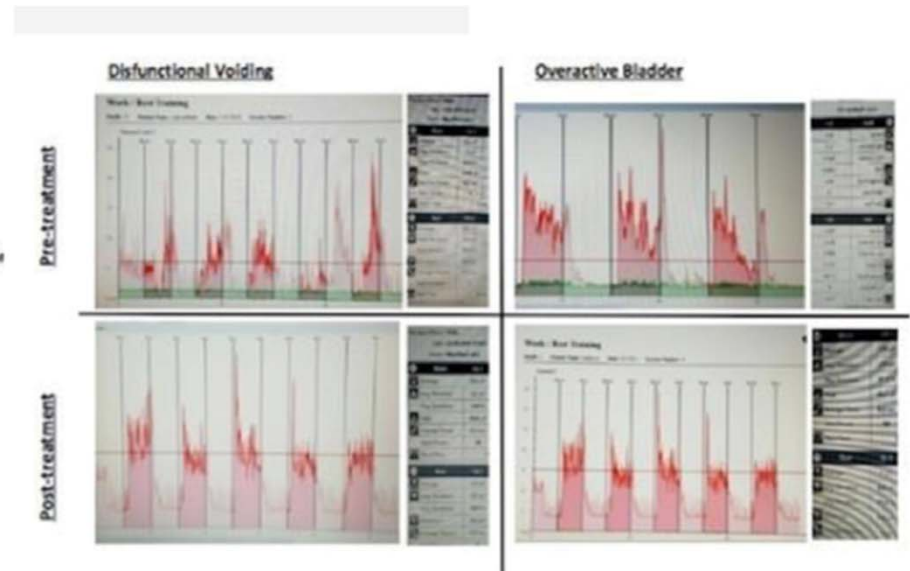
- 98 hasta
- 102 üreterosel (42 sol, 52 sağ, 4 bilateral)
- Ortalama 64 ay takip
- Küçük:4-15mm
- Büyük:15-34mm
- Büyük üreterosellerde üreterosel insizyonu sonrasında daha çok ek tedavi gereksinimi ve uzun dönem komplikasyon izlenmiş.
- İlk bir yaş içerisinde izlenen ateşli idrar yolu enfeksiyonu açısından fark yok.

Yelda Pekbay, Bahadır Topuz, Selcuk Sarikaya, Yasemin Irkilata, Hasan Cem Irkilata, Musa Murat Dayanc

- BBD'nin farklı tiplerinde pelvik taban kas aktivitelerinin tedavi öncesi ve tedavi sonrası değerlendirilmesi.



Before Treatment		After Treatment	
Contraction	Relaxation	Contraction	Relaxation
9.2	3.3	19.3	2.0



Sonuç

- BBD'li çocukların takibinde pelvik taban kas aktivitesi ölçümü girişimsel olmayan bir teknik olarak kullanılabilir.

Outcomes of ureteroscopy (URS) for stone disease in the paediatric population: Results of over 100 URS procedures from a UK tertiary centre

Authors: Patrick Jones P, Stephen Griffin, Bhaskar K Somani

- 16 yaş ve altı toplam 81 hasta 102 operasyon
- Ortalama yaş 8.8yıl

Stone location	Upper pole – 8.8%
	Mid pole – 12.7%
	Lower pole – 35.4%
	Renal pelvis – 16.5%
	Upper ureter – 5.1%
	Mid ureter – 6.3%
	Distal ureter – 15.2%

TABLE 2. KEY RESULTS

Pre-operative stent	35/102 (34%)
Post-operative stent	61/102 (60%)
Access sheath use	21/102 (20.5%)
Initial stone free rate	87%
Final stone free rate	99%
Number of URS procedures/ patient for being stone free	1.26 (range: 1-3) 61 – 1 procedure 19 – 2 procedures 1 – 3 procedures
Length of stay	1.2 days (range: 1-5 days)
Complication rate	3%
Re-admission rate	0.9%

COMPLICATIONS

- 1 x Pain control  Prolonged admission (GRADE I)
- 1 x Urinary retention  Catheterised (GRADE II)
- 1 x Urosepsis  ITU admission (GRADE IV)

CONCLUSION

- **Largest reported series in UK** (top 10 in the world)
- In the appropriate setting, paediatric URS can achieve:
 - ✓ **High stone free rates**
 - ✓ **Minimal morbidity**



Hypospadias complexity score (HCS): A new tool for predicting operating time and complications in hypospadias surgery

Bandini M.^{1,2}, Sekulovic S.², Stanojevic N.², Slavkovic M.², Spiridonescu B.³, Dangi A.D.⁴, Krishnappa P.⁵, Pesic V.², Briganti A.¹, Salonia A.¹, Montorsi F.¹, Djinojic R.²

¹ Urological Research Institute (URI), San Raffaele Hospital, Vita-Salute San Raffaele University, Unit of Urology, Milan, Italy; ² Sava Perovic Foundation, Center for Genito-Urinary Reconstructive Surgery, Belgrade, Serbia; ³ Fundeni Clinical Institute, Center for Urology and Renal Transplantation, Bucharest, Romania; ⁴ Christian Medical College and Hospital, Dept. of Urology, Vellore, Tamil Nadu, India; ⁵ NU Hospitals, Dept. of Urology, Bangalore, India



HCS	0 pts	1 pts	2 pts
UM location	distal	midshaft	proximal
Penile skin	abundant	normal	poor
Penile curvature	<30°	30-60°	>60°
Scrotum	normal	bifid	penoscrotal transposition
Pubis	normal	hypertrophic	

Conclusions

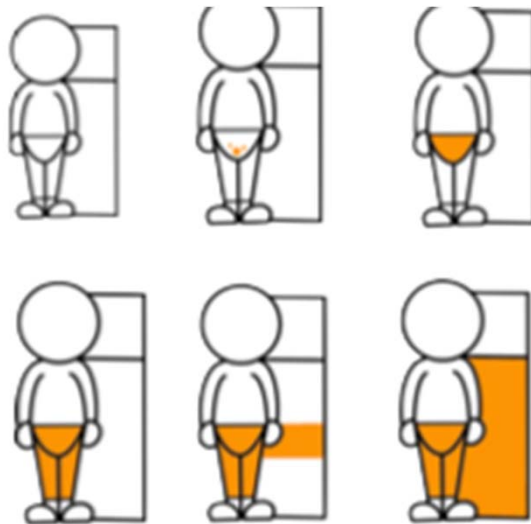
Preoperative clinical evaluation of hypospadias patients should account for all penile and scrotal malformations instead of the location of UM alone. Our HCS was multivariably correlated with surgery duration and the risk of postoperative complications. The use of the HCS showed increased (+8%) predictive accuracy of postoperative complications compared with the use of UM-based model.

Clinical utility of a grading scale of urinary incontinence (ENURI) in children with monosymptomatic enuresis

Romeu-Magraner G.¹, March-Villalba J.A.¹, Arlandis-Guzmán S.², Sánchez-González J.V.¹, Serrano-Durbá A.¹, Polo-Rodrigo A.¹, Conca-Baenas MA.¹, Domínguez-Hinarejos C.¹, Boronat-Tormo F.¹

(¹ University and Polytechnic Hospital La Fe Valencia, Dept. of Paediatric Urology, Valencia, Spain, ² University and Polytechnic Hospital La Fe Valencia, Dept. of Reconstructive and Functional Urology (SURF), Valencia, Spain)

- Amaç: İnkontinansın ciddiyetini değerlendirmek ve takiplerde kullanılabilecek görsel bir araç geliştirmek.
- 60 hasta 12 ay boyunca takip edilmiş.



ENURI grades	MVU
0	0 ml
1	7 ml
2	74 ml
3	319,5 ml
4	363,6 ml
5	503,6 ml

- İşeme günlüğü ve ped kullanılarak karşılaştırma yapılmış.

CONCLUSIONS

ENURI scale can accurately reflect the incontinence situation of the child with ME and his evolution, avoiding diaper weighing, presenting a good feasibility and sensitivity to change.
ENURI grades facilitates communication with parents and could be useful for proposing objectives within a programmed therapeutic plan for these patients.

**Relationship between 25-hydroxyvitamin D, vitamin B12, folate and primer nocturnal enuresis (PNE) in five to thirteen years old children:
A single center cohort study**

Keles A.¹, Karakeci A.², Onur R.³

1. Istanbul Esenyurt State Hospital, Dept. of Urology, Istanbul, Turkey, 2. Firat University School of Medicine, Dept. of Urology, Elazig, Turkey, 3. Marmara University School of Medicine, Dept. of Urology, Istanbul, Turkey.

- Primer nokturnal enürezisi bulunan, geç preterm doğum çocuk hastalarda Vitamin B12, folat, demir ve 25-OH D ilişkisini araştırmak.
- 146 hasta çocuk ve 111 kontrol
- Demir-demir bağlama ve ferritin açısından fark izlenmemiş.

- Mevcut literatür ile uyumu olarak B12 ve 25-OH D seviyelerinin hasta çocuklarda istatistiksel olarak anlamlı şekilde düşük olduğu bulunmuş.
- B12 vitamini ve 25-OH D'nin santral sinir sistemi gelişimi ve uyku bozukluklarında rolü olduğu düşünülmekte.
- Primer nokturnal enüreziste bu testlerin değerlendirmede rutin kullanıma girebileceği düşünülmekte.
- Bu konuda dünyadaki en büyük hasta serisi

Morphological evaluation of operated testes for cryptorchidism: New findings

Zampieri N.^{1,2}, Caridha D.¹, Patanè S.¹, Bruno C.¹, Bianchi F.¹, Camoglio F.¹

¹Azienda Ospedaliera Universitaria Integrata, University of Verona, Dept. of Pediatric Surgery, Pediatric Adolescent Fertility Lab, Verona, Italy,

²Azienda Ospedaliera Universitaria Integrata, Dept. of Radiology, Verona, Italy

- Orşiopeksi yapılan hastalarda USG elastografi kullanılarak testis morfoloji ve volümünün orta-uzun dönemde değerlendirilmesi amaçlanmıştır.
- Retrospektif olarak yapılmıştır.
- 18ay-13 yaş
- Hastalar 2 gruba ayrılmıştır: cerrahinin yapıldığı yaş ve cerrahiden görüntülemenin yapıldığı zamana kadar geçen süre.

- Parankim kalitesi elastografiyle 3 ayrı grupta sınıflandırılmış.
- 68 hasta çalışmaya dahil edilmiş.
- Takiplerde operasyondan tetkike geçen zamanla elastografi bulgularının iyileşmediği gözlenmiş.
- 3 yaştan küçük opere edilen hastaların elastografileri sabit kalmakta ancak daha geç opere olanlara göre daha iyi.

- Orşiopeksi sonrası değerlendirme genellikle fizik muayene ile testis kıvamının değerlendirilmesi ve ultrason ile boyut değerlendirilmesi.
- Elastografi ile kalitenin değerlendirilmesi bu hastaların gelecek fertilité potansiyellerini değerlendirmede anlamlı bir araç olabileceđi öne sürölmekte.

Teşekkürler