many patients do not accept self injection and many others drop out of treatment. Recently, Trimix has been compuounded as a gel. Delivery of trimix gel into the urethral meatus offers a simple alternative for these patients, because this site is easy to access and the mucosa has excellent absorption This video will demonstrate a unique system for the use of trimix in gel in clinical practice.

METHODS: Sixteen men were on antihypertensive meds, 12 had type II diabetes, 8 had high cholesterol and 6 were post radical prostatectomy. Ten men had comorbidies. Prior to the gel, an EHS was recorded for the experience with oral agents. The trimix active ingredients and 0.3ml of gel were maintained in separate interlocking syringes at room temperature until the time of use. The final preparation was completed by vigorous mixing between the interlocking syringes. The mixed gel was inserted painlessly into the urethral meatus with a rounded adapter and the patient massaged the outer glans for 2 minutes to promote absorption. There was no other form of stimulation. After the gel, an EHS was recorded for each patient. In addition, 9 had measurement of buckling pressures and 7 had rigiscans.

RESULTS: For all 42 patients (mean age 55.2 yrs) the EHS was recorded as 1 for the oral agents (penis was larger but not hard), but 22 of these patients actually had no increase in size. After the gel, the mean EHS was 2.2, but 11 patients had an EHS of 3 (26.1%) and 6 had a 4 (16.6%). Thus, 40.4% of the study group had erections that were sufficient for penetration. In those with an ESH of 4, the buckling pressure was $>$90mm Hg. The rigiscans provided real time information about the gel response and documented some tumescence in all cases. In a comparison of 3 and 4 scores, oral agents vs. gel, $X^2 = 10.0$, df 1, $p<0.001$.

CONCLUSIONS: Trimix gel has may have several advantages over oral agents and intracavernous injections. The active ingredients and gel may be carried by the patient at room temperature. The shelf life is long because the active ingredients are mixed only at time of use. The interlocking syringes permit thorough mixing. Administration is painless and massage of the glans may enhance mucosal absorption. Even without stimulation by a partner or videos, these patients demonstrated statistical significant greater EHS with gel versus oral agents. These pilot data support the use of trimix in gel form for ED, but more prospective trials are needed.

Source of Funding: None

V1398

TRANSPERINEAL REPAIR OF INTRACAVERNOUS ARTERIOSINUSOIDAL FISTULA FOR MANAGEMENT OF NON-ISCHEMIC PRIAPISM

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INTRODUCTION AND OBJECTIVES: Non-ischemic priapism is the condition in which an unregulated flow of arterial blood from a ruptured cavernous artery leads to a semi-tumescent and typically painless erection. It is almost universally associated with a recent history of trauma to the perineum or groin. The condition can be bothersome to men and in some cases may impair sexual function. Management with angioembolization is the most commonly utilized therapy for definitive treatment but carries the risk of erectile dysfunction from arterial disruption. We report a case of non-ischemic priapism refractory to angioembolization that was successfully managed with transperineal repair of an arteriosinusoidal fistula.

METHODS: An otherwise healthy 21 year old man presented to our clinic with a 3 year history of painless partial penile erection and difficulty maintaining full erection during attempts at intercourse. He had failed angioembolization three times. A proximal right corporal arteriosinuosoidal fistula was identified by color Doppler ultrasonography. He was taken to the operating room for transperineal exploration of the right corporal body and surgical repair of the fistula. The fistula cavity was identified and a series of 4-0 PDS sutures were utilized to imbricate and collapse the fistula cavity and its' vascular tributaries. The patient was treated with a one month course of nightly ketoconazole to suppress nocturnal erections after surgery.

RESULTS: The patient had resolution of partial tumescence on post-operative day one. Repeat Doppler ultrasound was demonstrative of persistent cavernous artery flow in the right proximal corpora with complete ablation of the fistula cavity. At one month follow-up the patient reported complete baseline flaccidity with an increase in his capacity to maintain penile erection during sexual arousal. Doppler ultrasound again confirmed no recurrence of the fistula cavity. At two-month follow-up the patient reported complete return of erectile function and great satisfaction with the procedure.

CONCLUSIONS: Transperineal surgical repair of arteriosinusoidal fistulae is safe and effective in the management of non-ischemic priapism. Excellent functional outcomes can be attained with this intervention.

Source of Funding: None

V1399

THE ROLE OF LAPAROSCOPY IN THE CONTEMPORARY MANAGEMENT OF IATROGENIC UROLOGIC TRAUMA

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INTRODUCTION AND OBJECTIVES: Most urologists will encounter iatrogenic urological trauma relatively infrequently. Many situations can be appropriately treated with conservative or endoscopic management. Where this is not possible reconstruction is required. Our series describes how reconstructive intervention can be safely undertaken using minimally invasive techniques.

METHODS: Over a twenty-four month period six cases including three bladder injuries and three ureteric injuries were repaired laparoscopically, one with robotic assistance. Four of the cases were the result of gynaecological laparoscopy (three ureteric injuries and one bladder perforation.) Two further bladder perforations resulted from a cold cup bladder biopsy, and a traumatic catheterisation in a patient with radiation cystitis.

RESULTS: The bladder injuries were all primarily closed in two layers, followed by flexible cystoscopy to ensure watertight closure and to exclude additional occult bladder injuries. Two of the ureteric injuries required re-implantation one of which utilised a modified psoas hitch, and the remaining ureter was primarily repaired with a spatulated anastomosis. All ureteric repairs were stented intra-operatively. All patients made an uneventful recovery. No patients required conversion to an open procedure. Other than stent removal no additional procedures have been required

CONCLUSIONS: We feel that laparoscopy when clinically appropriate should be considered for the management of iatrogenic urological pelvic trauma. Standard open surgical principles and techniques are adhered to. This patient group will potentially have a high morbidity and mortality from their complication and requirement for further surgery, and therefore are more likely to benefit from minimally invasive intervention over open repair.

Source of Funding: None

V1400

CIRCUMFERENTIAL HOLMIUM LASER ABLATION OF URETHRAL STRICTURE

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INTRODUCTION AND OBJECTIVES: To evaluate feasibility, safety and short term efficacy of transurethral Holmium laser circumferential ablation of urethral stricture. The hemostatic nature of the holmium laser along with its haemostatic property makes it an ideal energy source for ablation of urethral stricture. It was our presumption that removal of the fibrous tissue may help to minimize the possibility of recurrent stricture and improve the results of endoscopic managment of urethral stricture.

METHODS: From April 2003 to September 2009, 72 patients underwent circumferential holmium laser ablation of urethral stricture at