ELECTIVE IMPLANTS IN FEMALE-TO-MALE TRANSEXUALS: OUR EXPERIENCE IN 130 PATIENTS

Lumen N.1, Monstrety S.2, Decaestecker K.1, Opdenakker Y.1, Beyens M.1, Hoebeke P.1

1University Hospital Ghent, Dept. of Urology, Ghent, Belgium, 2University Hospital Ghent, Dept. of Plastic Surgery, Ghent, Belgium

Introduction & Objectives: Female-to-male transsexuals who desire sexual intercourse still need an elective implant in their reconstructed phallus. Less is known about the complications of this surgery in female-to-male transsexuals. We reviewed the complication rate of elective implant surgery at our centre.

Material & Methods: On a total of more than 300 female-to-male transsexuals, 130 patients received an elective implant between December 1997 and October 2007. Different types of prostheses were implanted: Dynaflex® in 9 patients, AMS CX®, AMS Ambicor® and Porges® in 68, 47 and 6 patients respectively. Mean follow-up was 22.2 months (range: 1-118 months). We reviewed the complication rate and cause of explantation in each group.

Results: Of the 130 patients, 72 patients (55.4%) still have their original implant in place. Fifty-eight patients (44.6%) needed to undergo either removal of the prosthesis due to infection or erosion (18 patients-13.8%) or revision due to dysfunction or leak (40 patients-30.8%). In the Dynaflex®-group, 8 of 9 patients needed revision due to dysfunction (88.9%) but no removals due to infection, protrusion or leakage were reported. In the Porges®-group, only 1 of 6 patients (16.7%) needed revision due to dysfunction but no other complications were reported. In the AMS CX®-group, 33 of 68 patients (48.5%) needed explantation due to infection, erosion, dysfunction or leakage in respectively 8 (11.8%), 2 (2.9%), 11 (16.2%) and 12 (17.6%) patients. In the AMS Ambicor®-group, 16 explantations (34%) were done because of infection, erosion, dysfunction and leakage for 4 patients each.

Conclusions: Despite a high explantation rate (44.6%) due to infection, erosion, dysfunction or leakage implantation of an elective implant is the only available option for female-to-male transsexuals to obtain satisfactory intercourse. Patients must absolutely be informed about these possible complications but should not be discouraged.

EXTERNAL-BEAM RADIATION THERAPY INCREASES THE RATE OF SECONDARY MALIGNANCIES RELATIVE TO RADICAL PROSTATECTOMY IN MEN WITH RADICAL PROSTATE CANCER

Saad F.1, Montorsi F.2, Karakiewicz P.I.1

Introduction & Objectives: The increased rate of secondary malignancies after EBRT should be considered in localized prostate cancer treatment decision-making.

Material & Methods: On a total of more than 300 female-to-male transsexuals, 130 patients received an elective implant between December 1997 and October 2007. Different types of prostheses were implanted: Dynaflex® in 9 patients, AMS CX®, AMS Ambicor® and Porges® in 68, 47 and 6 patients respectively. Mean follow-up was 22.2 months (range: 1-118 months). We reviewed the complication rate and cause of explantation in each group.

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Conclusions: Despite a high explantation rate (44.6%) due to infection, erosion, dysfunction or leakage implantation of an elective implant is the only available option for female-to-male transsexuals to obtain satisfactory intercourse. Patients must absolutely be informed about these possible complications but should not be discouraged.

PHASE II STUDY OF HYPOFRACTIONATED RADIOTHERAPY (HYPOR) IN LOCALISED PROSTATE CANCER: REPORT ON ACUTE AND 18 MONTH LATE TOXICITY

Garcia-Rojo D.1, Macias D.1, González D.1, Gallardo D.1, Martos D.1, Ropero D.1, Vicente D.1, Abad D.1, Hannaux D.1, Prera D.1, Prats D.1

Hospital Sabadell, Dept. of Urology, Sabadell, Spain, 2Hospital General Catalunya, Dept. of Radiotherapy, Sant Cugat, Spain, 3Hospital Sabadell, Dept. of Medical Oncology, Sabadell, Spain, 4Hospital Hospitalitat, Dept. of Urology, Sabadell, Spain

Introduction & Objectives: Radiotherapeutic studies and preliminary results HYPOR trials seems to show that dose per fraction over 2 Gy is safe and can increase the therapeutic ratio. Before 10/2004 dose to prostate Planning Target Volume (PTV) in curative radiotherapy was 80-82 Gy in 2 Gy-fraction in 8.2 weeks at our institution. Our objective to implement HYPOR was to decrease late toxicity while maintaining same biochemical control (to keep same equivalent dose). Total treatment time to 3-Years hormonal treatment for locally advanced prostate cancer (PCa). In EORTC trial 22961 70 Gy EBRT and 6 months of androgen deprivation (SADT arm) was compared to the same treatment followed by 2.5 further years of LH-RH agonist monotherapy (LADT arm), aiming non inferior overall survival (OS) and possibly earlier recovery of testosterone on the SADT-arm.

Material & Methods: Eligible patients had T1c,N0,M0 or T2c,N0,M0 PCa (UICC 1992) with PSA <150ng/ml. Interim analysis was performed at 11% of patients treated with either 70 Gy EBRT followed by 6 months of combined androgen deprivation (SADT arm) or 70 Gy EBRT followed by 6 months of combined androgen deprivation (LADT arm).

Results: 970 patients were randomized (483 SADT and 487 LADT). At 6.4 years median follow-up, 230 patients had died (132 vs. 98). The patient characteristics were well balanced: median age 69 years, WHO PS 0 in 84.0%, 87.4% of the patients had T3-TN0N0 PCa. In EORTC trial 22961 70 Gy EBRT and 6 months of combined androgen deprivation (SADT arm) was compared to the same treatment followed by 2.5 further years of LH-RH agonist monotherapy (LADT arm), aiming non inferior overall survival (OS) and possibly earlier recovery of testosterone on the SADT-arm.

Material & Methods: External-beam radiation therapy (EBRT) on the rate of secondary malignancies in patients with localized prostate cancer. Excluding results were reported. We addressed the association between EBRT exposure and secondary malignancies rate in a large administrative database.

Material & Methods: The study population consisted of 10,333 men treated with radical prostatectomy (RP) (n=6196) or EBRT (n=4137) between 1983 and 2004 without neo- or adjuvant hormonal therapy. The diagnosis of bladder, lung and colorectal cancer was established with the ICD-9 and surgery codes, that defined extirpative interventions aimed at eradicating these three malignancies (cystectomy, lobectomy or pneumectomy and colectomy with or without rectal resection). Univariable and multivariable Cox regression analyses addressed the rate of secondary malignancies (bladder, lung and rectal cancer).

Results: Overall, 92 (0.9%) cystectomies, 82 (0.8%) lung cancer surguries and 228 (2.2%) surgeries for colorectal cancers were performed. In univariable analyses, the rate of cystectomies (log-rank p=0.002), of treatments for lung cancer (log-rank p=0.001) and for colorectal cancers (log-rank p<0.001) were higher in patients treated with EBRT relative to patients treated with RP. At multivariable analyses, after adjusting for age, baseline comorbidities and year of treatment (coded in quartiles), EBRT predisposed to a 3.0-fold higher rate of cystectomy for bladder cancer (p=0.04), to a 1.8-fold higher rate of lung cancer resections (p=0.02) and to a 1.7-fold higher rate of rectal cancer (p=0.02).

Conclusions: The increased rate of secondary malignancies after EBRT should be considered in localized prostate cancer treatment decision-making.