52.9% and lateral in the 17.2%, with a median of 60° (IQR 45–70°). The average follow-up time was 97 months. The median hospital stay was 2 days for both groups. Postoperative haematoma were more frequent (p = 0.003) in the group A when compared to the group B. Postoperative complications, in terms of bleeding, infection or unsatisfactory scarring, resulted a rare event (13.6%) without a significant difference in-between groups. A recurrent curvature was observed in 9.9% of cases. A minor residual curvature (<20°) was detected in 14.8% of patient. Long-term postoperative erectile dysfunction (ED) was observed in 3.2% of case in group A and in 43.5% in group B (p = 0.001). Long-term PROs demonstrated a higher incidence of dissatisfaction for penile length loss in group B compared to group A (p = 0.001). An higher improvement of quality of both everyday life and sexual life was observed in group A compared to group B (p = 0.01; p = 0.004). PD, age (>35) and postoperative complications were identified as Independent risk factors for the development of postoperative ED.

Discussion: Turin’s corporoplasty represents an easy and effective approach. Despite low incidence of postoperative complications, both functional and PROs tend to be sharply lower in patients with PD curvature compared to congenital deformations.

P45 Is degloving mandatory in penile corporoplasty with Yachia’s technique?


Aim of the Study: Peyronie’s Disease (PD), congenital and acquired penile curvature represent three separate types of penile curvature deformities. Surgical correction of the curvature is indicated when the deformity inhibits vaginal penetration or erectile function. Penile corporoplasty with Yachia’s technique (CYT) with degloving (DG) or without degloving (WDG) provides a minimally invasive option for treatment of penile curvature. The purpose of this study was to review the outcomes of penile CYT with DG and WDG of the penis.

Materials and Methods: Clinical data and operative outcomes of 71 patients (pts) who underwent penile plication were reviewed. The preoperative characteristics of the pts (age, direction of curvature, degree of angulation, IIEF-5 score and presence of plaque), postoperative outcomes (change in angulation, palpation of sutures, penile shortening, patient satisfaction and postoperative IIEF-5), operative time and hospital stay were recorded. All pts were asked about their sexual satisfaction status (which was as “excellent,” “satisfied,” or “poor”). Pts without at least 6–months of follow-up were not included in this study. Statistical analysis was performed using SPSS 23.0. Normally and non-normally distributed variables were presented as mean±SD (compared using Student t-test) and median (compared using the Mann-Whitney U-test), respectively. A P value <0.05 was considered statistically significant.

Results: A total of 71 pts were admitted for penile CYT, out of which 8 pts were excluded. 63 pts were included in the study and divided into two groups: 33 pts in Group I (DG) and 30 pts in Group II (WDG). The mean age of the patients was 49.01 ± 18 years. The diagnosis of penile curvature was PD in 41pts, congenital curvature in 19pts, and acquired curvature (after a penile surgery) in 3pts. The two groups were similar in age, IIEF-5, direction and degree of curvature. The mean operative time was 65.87 ± 21.32 minutes for Group I and 49.17 ± 24.82 minutes for Group II (p = 0.02). The mean hospital stay was 3.08 ± 0.96 and 2.97 ± 0.93 days in DG and WDG, respectively (p = 0.324). There were no complications during surgery in either group. The median follow-up was 19.4 (range 6–36) months. There were no significant differences in recurrence rates and complications [palpation of sutures: (DG:10%; WDG:12.1%), penile shortening (DG:0; WDG:0), IIEF-5 score (DG:17.81 ± 4.80; WDG:17.01 ± 4.63)]. One patient in the Group II underwent reparation due to inadequate surgical correction (p = 0.526). One patient in Group I reported gland hypoesthesia. All pts reportedly had resumed their sexual activity at 1 month postoperatively. When sexual satisfaction after surgery was reviewed in the DG group (63.6%: excellent, 27.3%: satisfied, and 9.1% poor), while in the WDG group (63.4%: excellent, 23.3%: satisfied, and 13.3% poor) (p = 0.526).

Discussion: CYT with DG or WDG is safe and effective for treatment of penile curvatures. The outcomes of the DG and WDG techniques were similar in outcomes, but not in length of operative times.

P46 Percutaneous angioplasty of Internal pudendal Arteries for the treatment of Erectile Dysfunction not responsive to pharmacological therapy. Initial experience in six patients


Aim of the Study: To assess the feasibility and efficacy of percutaneous angioplasty of Internal Pudendal Arteries (IPA) stenosis with drug-eluting paclitaxel-mediated balloons in the treatment of Erectile Dysfunction (ED) no longer responding to pharmacotherapy.

Materials and Methods: Six patients with severe ED no longer responsive to oral and intracavernosal pharmacotherapy were treated. The mean age was 61 ± 5 years old. Serum testosterone and prolactin levels were normal in all patients. IIEF-5 ranged between 3 and 7 (mean 4.8). The penile Dynamic Colour Duplex Doppler Ultrasound (D-DDU) detected arteriogenic ED with Systolic Peak Velocity (PSV) between 18 and 25 cm/sec (mean 21.8). Penile rigidity was grade 1 on 4 according to Erection Hardness Score. Through a single or bilateral femoral percutaneous access, patients underwent selective angiography of internal iliac arteries and IPA. Angiographically significant stenosis of IPA (diameter obstruction >50%) were observed bilaterally in five patients and unilaterally in one. Stenosis were gradually dilated with 2.0, 2.5 and 3.0 mm diameter medicated balloons. All patients were discharged one or two days after angioplasty on double antiplatelet therapy (clopidogrel 75 mg + ASA 100 mg) and atorvastatin 40 mg die.

Results: All procedures were successful in restoring of good IPA flow. No complications occurred. Patients were followed at 4 and 8 months. At the first check all patient reported a significant improvement in erections with an average increase of 9 points in the IIEF-5. Three patients had to use sildenafil 100 mg and three 50 mg to have good erections. D-DDU detected an average increase of 13.5 cm/sec in PSV. At eight months, one patient was regressed at the initial state because and underwent prosthesis placement; two patients had to use alprostadil 10 ug and three had satisfactory erections using Sildenafil 100 mg.

Discussion: IPA stenosis angioplasty with paclitaxel-eluting balloons seems to be a promising therapy for ED not responsive to pharmacotherapy. It is a safe and repeatable procedure, leads to improvement of erectile function in a good percentage of cases and should be considered as a last therapeutic opportunity before proposing a penile prosthesis.

P47 The efficacy of combined low intensity shock wave therapy (LI-ESWT) and tadalafil 5 mg daily in diabetic patients with Erectile Dysfunction (ED): The results of a case-control retrospective study

P. Verze, M. Creta, F. Persico, A. Palmieri, C. Iimbimbo, R. La Rocca, V. Mirone (Università degli Studi di Napoli Federico II, Napoli)

Aim of the Study: To evaluate the efficacy of combination therapy with Low Intensity Shock Wave Therapy (LISWT) and Tadalafil 5 mg
was set at 0.09 mJ/mm² and frequency at 120/min. The number of duration of each LI-ESWT session was about 20 min. Energy density focused shockwave source. Shockwaves were delivered to the distal, delivered by a probe attached to an electrohydraulic unit with a focused shockwave source. Shockwaves were delivered to the distal, mid, and proximal penile shaft, and the left and right crura. The duration of each LI-ESWT session was about 20 min. Energy density was set at 0.09 mJ/mm² and frequency at 120/min. The number of shock waves delivered during each session varied from 1500 to 2400. Treatment protocol consisted of 2 treatment sessions per week for 3 weeks. Patients with same demographic and clinical characteristics who received only TAD oad for 12 weeks served as controls (Group 2). International Index of Erectile Function (IIEF-5) scores recorded at baseline, at 4 and 12 weeks after the end of the treatment were compared. A subgroup analysis was performed according to the number of shock waves administered during each session (1500, 1800, 2400).

**Results:** Thirty-one and 10 patients were enrolled in Group 1 and 2, respectively. Eleven, 10 and 10 patients belonging to the Group 1 received 1500, 1800 and 2400 hits, respectively. Mean baseline IIEF-5 scores were 16.8 and 15 in Group 1 and 2, respectively (p = 0.09). A statistically significant improvement of mean IIEF-5 score was observed in both groups at 4 weeks follow-up (19.7 and 18.3 in Groups 1 and 2, respectively) (p < 0.05 vs baseline). Mean IIEF-5 scores recorded at 12 weeks did not varied significantly in comparison to values recorded at 4 weeks (p = 0.1 in both groups). Inter-group analysis did not show significant differences at 4 and 12 weeks (p = 0.2 in both cases). Subgroup analysis revealed a statistically significant improvement of mean IIEF-5 score at 12 weeks with respect to 4 weeks only in patients who received 2400 hits (Figure 1). The percentage of patients in which it was registered a normalization of erectile function after 12 weeks of treatment was 20%, 27.2%, 20% and 50%, in Group 2 and in the subgroups of Group 1 treated with 1500, 1800 and 2400 hits, respectively.

**Discussion:** The combination of TAD oad and LISWT leads to a statistically significant improvement of erectile function in diabetic patients with concomitant ED at 4 weeks follow-up, with a stable trend over time up to 12 weeks. The administration of 2400 hits for session allows to get an additional, significative improvement of erectile function at 12 weeks follow-up.

**P48**

**Clinical indications for penile prosthesis implantation: Data from the national prospective registry of penile prosthesis implantation “INSIST-ED”**


**Aim of the Study:** The European Urological Association (EAU) guidelines suggest penile prosthesis implantation (PPI) only as a third line therapy for the treatment of erectile dysfunction (ED), despite excellent results in terms of patients’ satisfaction and overall safety. We looked at the current indications for PPI in clinical practice using data from a prospective national registry.

**Materials and Methods:** Data from a national multi-institutional database of PPI including patients treated from 2014 to 2017 in Italy (INSIST-ED) were analyzed. Data have been prospectively recorded by 45 surgeons on a dedicated website (www.registro.andrologiaitaliana.it) and revised by a single datamanager. Clinical characteristics, ED etiology and hospitalization regimens were analyzed for every patient. According to EAU guidelines, the indication for PPI was considered appropriate when patients had been offered both a first line (e.g. PDE5is and/or vacuum therapy) and a second line (e.g. intracavernous injection [ICI]) treatment approach before surgical treatment. Likewise, patients with penile curvature and ED were considered as properly submitted to PPI when they were previously offered at least with PDE5is. Logistic regression analyses tested the association between clinical characteristics, surgeon experience and ED etiology with the likelihood of a proper indication for PPI.

**Results:** Complete data were available for 579 patients; median (IQR) age was 61 (56–67) years. ED etiology was vasculogenic in 39% (226) and post-pelvic surgery in 40% (231) of cases, respectively. Overall, only 20 (3.5%) patients did not have a proper indication for PPI according to EAU guidelines. Of them, 14 (70%) and 6 (30%) were either nonresponders to or refused a first-line ED therapy and were not offered with a second line therapy prior to surgery. Moreover, most patients with a proper PPI indication were treated in a public center [442 (79%) vs. 117 (21%)]. Both nonresponders to a previous ED therapy (OR: 3.3; 95%CI: 1.2–9.1, p = 0.01) and patients treated in a private center (OR: 2.51; 95%CI > 1.01–6.3, p = 0.04) were more likely to undergo PPI surgery without a proper indication according to current EAU guidelines. No significant association was found between ED etiology, surgeon’s experience and patients’ age and the likelihood of a proper indication for PPI.

**Discussion:** Current findings from a national registry showed that EAU guidelines are properly followed in terms of indications for PPI surgery in patients with ED. Patients treated in a private hospital setting and those nonresponders to a previous first-line treatment were more likely to be counseled for PPI before being offered a second-line therapy.

**P49**

**Comparison of outcomes and satisfaction of hydraulic and non hydraulic penile implants: Prospective data from a 207 patients monocentric series**


**Aim of the Study:** The choice between hydraulic and non-hydraulic prosthetic implant is carried out considering surgeon’s experience, economic issues, anatomical-clinical conditions and personal preferences of the patient. Few data are available in the literature.