in cases clinically suggestive for having an urge component and patients suffering from detrusor hyperactivity were excluded. Pad use and Stamey grading of the incontinence (0 to 3) were assessed prior to injection and again at last follow up. PDS injection was repeated if the initial treatment was not curative. PROs were assessed by telephonic interview using questionnaire including three standardized items exploring on Likert-like scales (higher score- better outcome): The patient's global impression of improvement (PGI-I; score 1-7), patient-reported satisfaction (PSat; score 0-5) from the treatment and patient-reported success (PSuc; score 0-5) of the procedure. Non parametric statistic was used for comparisons.
Results: Of 35 patients, 33 were available for evaluation and 2 were lost to follow up. Mean follow up was 14 months (range 2-31). Mean Stamey grade before treatment was 2.1. 22 patients underwent only one injection, 13 patients underwent further injection (10 pts 2 injections, 3 pts 3 injections). Mean PDS volume injected for patient was 5.42 ml (2.5 – 12). 5 patients experienced in the postoperative urinary retention cleared up in 24 hours. Based on the PGI-I item, the overall improvement rate (score ≥ 5) was 12% (4/33); mean PGI-I score was 3.92. Based on the PSat item, the overall satisfaction rate (score ≥ 3) was 12% (4/33); mean PSat score was 1.50. Based on the Psuc item, the overall success rate (score ≥ 3) was 11% (3/33); mean PGI-I score was 1.20. Corresponding mean value in pts undergoing one injection only or more than one injection were 4.1, 1.7, 1.4 and 3.7, 1.3, 1.1 respectively (p = N.S.). There was no statistically significative difference considering age or incontinence grading. Only 6 pts (18%) will recommend the treatment to someone else with the same problem and only 8 pts (24%) will undergo the treatment again. 6 pts (18%) underwent other surgical treatments (slings or AMS 800). No significant changes were found in Stamey grading and pad use (p > 0.1) at last follow up.
Conclusions: Our results with bulking agents on postoperative SUI in males using PDS injections are disappointing at a mean follow up period of 14 months.

235 A SIMPLE, LOW-COST AND VALID PLASTIC DEVICE, UFLOW-METER™ , TO CATEGORISE MALES HAVING LUTS WITH DIFFERENT PEAK MICTURITION FLOW RATES: PROSPECTIVE CLINICAL DIAGNOSTIC STUDY

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Introduction & Objectives: To estimate the diagnostic agreement between micturition flow measured by Uflow-meter™ when used at home and that measured by the electronic flowmeter when used in the hospital by a prospective clinical diagnostic study and to evaluate its ability to discriminate LUTS male with poor peak flow from those with 'acceptable/good' flow
Material & Methods: 54 male patients(mean age 65, range 50-80y.o.) with LUTS (meanQmax 13.5ml/sec, range:5.5-38.0; mean voided volume 287 ml, range151 – 537; mean PVR 46ml,range:0–147; mean IPSStotal 13.7, range:3-28)who can produce more than 150ml urine at flow clinic are invited for study after informed consent is obtained. They first perform uroflowmetry and fill out IPSS questionnaire. Their post-void residual(PVR) will be estimated by bladder scan. They are then asked to perform flow study using the device at home once a day for 10 days. Uroflowmetry, PVR and IPSS will be repeated 2 weeks later. The most frequently observed markings (MFOC) of the device will be selected as the category of the peak flow rate measured at home. (Mean voided volume of MFOC at home 280ml, range150–460). This will be compared to the mean peak flow rate(Qmax) of the uroflowmetry. The diagnostic agreement (weighted-Kappa analysis), sensitivity, specificity and diagnostic odd ratio of Uflow-meter™ to discriminate poor flow from 'acceptable/good' flow are worked out. Mean IPSS(total) is classified into 3 groups (mild: score < 8, moderate: score 8 – 19, severe: score > 19) so as to determine its capability of categorizing meanQmax < 10ml/sec, 10 – 15 ml/sec and > 15 ml/sec using weighted-Kappa statistics.
Results: The results are tabulated below

	Mean Qmax < 10 ml/sec	Mean Qmax 10 – 15 ml/sec	Mean Qmax 15 – 19 ml/sec	Mean Qmax >19 ml/sec	Subtotal
MFOC: bottom chamber	11	5	0	0	16
MFOC:Middle chamber	5	12	2	1	20
MFOC:Upper chamber	1	1	11	0	13
MFOC:Cup chamber	0	1	0	4	5
Sub-total	17	19	13	5	54

Weighted Kappa statistics of Uflow-meter™ :0.74 (SE: 0.15 ; 95%CI : 0.44 – 1.0). The diagnostic agreement is at least moderate and expected to be substantial. The corresponding figure of mean IPSS(total): 0.0025 (95% CI: 0.00 – 0.05).

	Sensitivity	Specificity	Diagnostic Odd Ratio
MFOC no higher than bottom chamber (To diagnose mean Qmax < 10ml/sec)	0.65 (CI: 0.41-0.83)	0.86 (CI:0.72-0.94)	11.73 (CI:3.0-46.2)
MFOC no higher than middle chamber (To diagnose mean Qmax < 15 ml/sec)	0.92 (CI: 0.78-0.97)	0.83 (CI: 0.61-0.94)	55.0 (CI:9.9-304.9)
MFOC no higher than upper chamber (To diagnose mean Qmax < 19ml/sec)	0.98 (CI: 0.89-1.00)	0.80 (CI: 0.38-0.96)	192.0 (CI: 10.0 – 3681.3)

Conclusions: Micturition flow categorized by Uflow-meter is in good agreement with the peak flow rate measured by electronic flowmeter. It is very sensitive in discriminating males with poor flow from good flow. IPSS fails to serve the same purpose.

236 TRANSRECTAL ULTRASOUND-GUIDED IMPLANTATION OF THE PROACT(TM) SYSTEM IN PATIENTS WITH POST-RADICAL PROSTATECTOMY STRESS URINARY INCONTINENCE: CLINICAL RESULTS AFTER A MEAN FOLLOW-UP OF 2 YEARS

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Introduction & Objectives: The ProACT system is an adjustable, permanent device for post-Radical Prostatectomy (RP) Stress Urinary Incontinence (SUI). Initially implantation was done with fuoroscopic guidance. Recently, safety and feasibility of Trans Rectal UltraSound (TRUS) guided ProACT implantation was demonstrated. TRUS provides good imaging of anatomical landmarks without radiation. This study evaluates the continence recovery of a cohort of male patients with SUI after RP, all treated with TRUS-guided ProACT implantation.
Material & Methods: Between June 2005 and March 2009, we operated on 79 consecutive patients (mean age 67.9 years, 51-82) with post-RP urodynamic intrinsic sphincter defiociency without detrusor overactivity. At baseline, all patients underwent urodynamic testing. Pads Per Day (PPD) used were recorded and patients completed the validated I-QoL questionnaire. The ProACT implantation was performed by a single surgeon using TRUS guidance (using a 7.5MHz linear and small convex probe).Safety was assessed by the incidence and severity of adverse events. Continence recovery was evaluated upon completion of balloon adjustments with efficacy determined by number of PPD used (0 or 1 safety pad=dry; >50% reduction=improved; <50% reduction=failure) and change in the I-QoL.
Results: At baseline, valsalva leak point pressure was 58cm H2O (30-110) and mean maximal urethral closure pressure was 44.9 cm H2O (9-100). Mean pre-operative PPD was 3.7 (1-10 or condom catheter) and mean I-QoL was 49 (±19.3).62 patients who completed balloon adjustments, with a mean follow-up of 25 months (3-45) are the object of this analysis. 41 (66.1%) are dry, 16 (25.8%) improved and 5 (8%) failed (all irradiated patients). Mean I-QoL score was 82.1 (±19.9 SD; p<0.0002). Perioperative complications included 2 bladder perforations (in irradiated patients). Post-operatively 3 unilateral balloon migrations and 2 urethral erosions occurred in 5 patients. Here the balloons were simply deflated and removed using local anesthesia.
Conclusions: ProACT appears to have a number of advantages over more invasive alternatives. It is implanted via a minimally invasive procedure with modest patient discomfort. Furthermore, it is easily adjustable at any time post-operatively, so that the optimal level of urethral resistance may be determined based on patient response. Moreover, if the system must be removed, there are no limitations to further surgical treatments for SUI. TRUS guidance for ProACT implantation is accurate, safe, avoids radiation exposure and results in success and complication rates which compare favourably with published data on ProACT implantation with fluoroscopic guidance. Irradiation seems a relative contra-indication. Larger series and a longer follow-up are mandatory to establish its long term safety, efficacy and durability.

237 PREVALENCE OF LOWER URINARY TRACT SYMPTOMS AND ERECTILE DYSFUNCTION: A POPULATION-BASED SURVEY OF SWEDISH MEN

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Introduction & Objectives: Lower urinary tract symptoms (LUTS) and erectile dysfunction (ED) are often bothersome conditions in ageing men. As better treatments of both LUTS and ED have emerged it has become important to investigate the frequency and bother from these conditions. The aim of this cross-