(range: 5-22) and had a mean age of 62.1 (range: 45-72) years. *Conclusion:* The retrospective review of this patient series suggests the potential role of preservation of one of the neurovascular bundles. In this patient series, MRP allowed recovery of sexual function in >50% of patients, with good oncologic outcome. However it is necessary to conduct prospective studies for further evaluation.

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THE EFFECT OF THE PRESENCE OF A MEDIAN LOBE ON THE OUTCOMES OF ROBOT-ASSISTED LAPAROSCOPIC RADICAL PROSTATECTOMY

Giancarlo Albo[1], Bernardo Rocco[1], Pietro Acquati[1], Rafael F. Coelho[2], Kenneth J. Palmer[2], Sanket Chauhan[2], Ananth Sivaraman[2] and Vipul R. Patel[2]

[1]Dipartimento di Scienze Chirurgiche Specialistiche Sezione di Urologia, Università degli Studi di Milano Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico U.O. di Urologia, Milano, Italy;
[2]Global Robotics Institute, Celebration, FL, U.S.A.

Aim: To report the effect of the presence of a median lobe on perioperative outcomes, positive surgical margin (PSM) rates and short-term urinary continence outcomes after robot-assisted laparoscopic radical prostatectomy (RARP). *Patients and Methods:* We analyzed data from 1,693 consecutive patients who underwent RARP by a single surgeon for treatment of clinically localized prostate cancer. Patients were categorized into two groups based on the presence or absence of a median lobe identified during RARP. Outcomes analyzed included operative time, estimated blood loss (EBL), nerve-sparing procedure, overall complication rates, length of hospital stay, days with catheter, presence of anastomotic leakage on cystogram, number of bladder neck reconstruction procedures, tumor volume, pathological stage, PSM rates, pathological Gleason score and continence rates. Continence was defined as the use of 'no pads' based on the patient responses to the Expanded Prostate Cancer Index Composite questions at 1, 4, 6, 12 and 24 weeks after catheter removal. *Results:* Median lobe was intraoperatively identified in 323 (19%) patients. Patients with a median lobe were slightly older (median 63 *vs.* 60 years, $p<0.001$), had higher PSA levels (median 5.7 *vs.* 4.7 ng/ml, $p<0.001$) and higher AUA-SS before RARP (10 *vs.* 6, $p<0.001$). The number of bladder neck reconstruction procedures (93.5% *vs.* 65.7%, $p<0.001$) and the median prostate weight (64 *vs.* 46 g, $p<0.001$) were also higher. Both groups had equivalent EBL, length of hospital stay, days with catheter, pathological stage, pathological Gleason score, nerve-sparing procedures, complication rates, anastomotic leakage rates, mean tumor volume, PSM rates and PSM rate at the bladder neck. The median OR time was slightly greater in patients with median lobe (80 *vs.* 75 minutes, $p<0.001$). There was no difference in the operative time between the two groups when stratifying this result by prostate weight. Continence rates were also equivalent between patients with and without a median lobe at 1 week (27.8% *vs.* 27%, $p=0.870$), 4 weeks (42.3% *vs.* 48%, $p=0.136$), 6 weeks (64.1% *vs.* 69.5%, $p=0.126$), 12 weeks (82.5% *vs.* 86.8%, $p=0.107$) and 24 weeks (91.5% *vs.* 94.1%, $p=0.183$). Finally, the median time to recovery of continence was similar between the groups based on the Kaplan–Meier curves (median: 5 weeks, 95% CI=4.41-5.59 *vs.* median: 5 weeks, 95% CI=4.66-5.34; log rank test, $p=0.113$). *Conclusion:* The presence of a median lobe does not affect perioperative outcomes, PSM rates and early continence outcomes in patients undergoing RARP performed by an experienced surgeon. There was a slight increase in the operative time in patients with a median lobe which was, however, related to the larger prostate size in this group.

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ANALYSIS OF THE CLINICAL PARAMETERS COMMONLY USED TO CHOOSE NERVE-SPARING PROSTATECTOMY FOR PATIENTS WITH POSITIVE BIOPSY AT THE TRANSITION ZONE ALONE

Michele Lanciotti, Lorenzo Masieri, Federico Lanzi, Saverio Giancane, Claudia Giannessi, Mauro Gacci, Andrea Minervini, Alberto Lapini, Marco Carini and Sergio Serni

Clinica Urologica I, Università di Firenze, Firenze, Italy

Aim: The aim of this study was to analyze the indication for nerve-sparing surgery for patients with positive prostate biopsies at the level of the transition zone (even in patients with PSA above10 ng/ml), the impact of this factor on biochemical recurrence-free survival (BCR) and extracapsular extension (ECE). *Patients and Methods:* The study included 273 patients undergoing open radical prostatectomy and pelvic lymphadenectomy for clinically organ-confined prostate cancer (OC), not submitted to neoadjuvant therapy, with preoperative biopsy of peripheral (PZ) and transitional zone (TZ). Clinical and pathological data were available from our prospectively maintained institutional registry of 936 consecutive patients. The correlation between clinicopathological parameters and the site of the biopsy were investigated with the chi-square and Mann–Whitney *U*-tests. The impact of these variables on biochemical progression-free survival was evaluated by Kaplan–Meier survival curves. *Results:* The mean follow-up was 26.9 (range, 7 62, median 24) months. The mean age was 65.7 (range 49-78, median 66) years. At the final pathological examination, 152/273 (55.6%) patients presented OC disease,

while 121 patients presented ECE, with a prevalence of 44.4%. We identified 54/273 patients (19.8%) with positive biopsies at the level of TZ only. Among these, 36 (66.7%) had PSA <10 ng/ml, 15 (27.7%) had a PSA in the range 10-20 ng/ml, and 3 (5.6%) >20 ng/ml. Of the 18 patients with PSA >10 ng/ml, only 3 presented ECE. The OC disease incidence in patients with positive biopsy only in the TZ and with PSA >10 ng/ml was significantly higher than in those patients with same PSA level and positive biopsy in the PZ alone ($p<0.05$). Patients with positive biopsy of the TZ showed a significantly higher incidence of OC tumor (83.3%) compared to those patients with positivity in the PZ alone (50.5%) ($p=0.014$). In univariate analysis, the localization (TZ or PZ) of the tumor did not prove to be predictor of relapse-free survival (p-value was non-significant): the BCR at five years amounted to 94.4% and 90.2%, respectively. Of the 54 patients with positive samples in the TZ, 51 (94.4%) had bioptic GS ≤6, three (5.6%) had bioptic GS=7, while 33 (61.1%) had a pathological GS ≤6, and 21 (38.9%) had a GS=7. *Conclusion:* Our records show that tumors diagnosed in the TZ alone are associated with a lower risk of ECE after radical prostatectomy. In particular, even with PSA >10 ng/ml, the probability of OC disease remains significantly higher than in patients with positivity of the PZ alone. These data should be assessed in order to extend the possibility of a nerve-sparing surgery to patients with positive bioptic cores only in the transitional zone and PSA>10 ng/ml.

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PAPILLARY UROTHELIAL NEOPLASM OF LOW MALIGNANT POTENTIAL: OUTCOME IN POST WHO/ISUP GRADING SYSTEM OF A SINGLE-CENTER COHORT

Roberto Giulianelli, Francesco Attisani, Luca Albanesi, Barbara Gentile, Stefano Brunori, Luca Mavilla, Gabriella Mirabile, Francesco Pisanti, Teuta Shestani, Giorgio Vincenti and Manlio Schettini

Urologia, Villa Tiberia, Roma, Italy

Background: Few long-term single-center studies have shown the outcome in patients affected by papillary urothelial neoplasm of low malignant potential (PUNLMP). The present study evaluated the behavior of *de novo* primary bladder PUNLMP lesions (Primary-PUNLMP) as well as Surveillance-PUNLMP (diagnosed during follow-up of a higher grade urothelial neoplasm). *Patients and Methods:* From January 2006 to January 2010, 478 patients (male=340, female=138; mean age 71.8±9.2 years) underwent transurethral resection (TURBT) of all visible tumors. We retrospectively analyzed our TURBT database and identified all patients with a histological examination which revealed a PUNLMP lesion type. *Results:* We identified a total of 43 PUNLMP of the bladder; 25 (58%) patients were categorized as Primary-PUNLMP and the remaining 18 (42%) patients were categorized as Surveillance-PUNLMP. During follow-up (range: 12-48 months), in the Primary-PUNLMP group, 14/25 (56%) patients did not develop any recurrences *vs.* 6/18 (33%) in the Surveillance-PUNLMP group. In the first group, 4/25 (16%) patients developed PUNLMP recurrence (1-2 episodes in 1-4 years) and 8/25 (32%) progressed to a higher grade lesion within 1-4 years. Grade progression was non-invasive low-grade urothelial carcinoma (LG-TCC) in 7 patients (28%) and non-invasive high-grade urothelial carcinoma (HG-TCC) in 1patient (4%). None of the Primary-PUNLMP patients developed muscle-invasive carcinoma or died because of disease progression. Tumor size did not correlate with the likelihood of recurrence. In the second group, 12/18 patients (67%) had PUNLMP during surveillance for higher grade urinary bladder lesions. These included 7 (58.3%) prior LG-TCC, 4 (33.3%) prior HG-TCC and 1 (8.3%) found in cystectomy for invasive neoplasm in bladder diverticula. Grade progression to LG-TCC occurred in 5 patients (27.7%), while progression to HG-TCC occurred in 6 (33.3%). Two patients (11.1%) died in the HG-TCC group and one patient (5.5%) died in the LG-TCC group died after developing a high-grade upper urinary tract tumor. *Conclusion:* Bladder PUNLMP can occur either as a *de novo* lesion or during surveillance for prior higher grade urinary bladder urothelial neoplasm. None of the Primary-PUNLMP patients in this study developed invasive carcinoma or died because of the disease despite 48% recurrence and 32% grade progression rates. Surveillance-PUNLMP was associated with a worse outcome (61.1% grade/stage progression, 16.6% deaths because of disease progression), most likely due to their initial higher grade/stage urothelial neoplasm.

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DOES PROSTATE WEIGHT AFFECT PERIOPERATIVE OUTCOMES, POSITIVE SURGICAL MARGIN RATES AND FUNCTIONAL OUTCOMES AFTER ROBOT-ASSISTED RADICAL PROSTATECTOMY PERFORMED BY AN EXPERIENCED SURGEON?

Pietro Acquati[1], Bernardo Rocco[1], Giancarlo Albo[1], Ananth Sivaraman[2], Sanket Chauhan[2], Kenneth J. Palmer[2], Rafael F. Coelho[2] and Vipul R. Patel[2]

[1]Dipartimento di Scienze Chirurgiche Specialistiche Sezione di Urologia, Università degli Studi di Milano Fondazione IRCCS Ca' Granda, Ospedale Maggiore Policlinico U.O. di Urologia, Milano, Italy;
[2]Global Robotics Institute, Celebration, FL, U.S.A.

Aim: To determine whether prostate weight has an impact on pathological, perioperative and early functional outcomes after