

tic tests (PSA and ultrasound-guided biopsies).

Conclusions: As in many other developed countries, prostate cancer screening activities are the likely cause of the increase in incidence and change in the management.

UP-02.114

Experience of Individual Screening of Prostate Cancer in Southern Tunisia

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Introduction and Objectives: To present the results of an individual screening investigation of prostate cancer in the Southern Tunisian's urology departments.

Material and Methods: Between January and December 2008, we conducted a prospective study on the population of southern Tunisian, from a non-blocked and early screening roommate patient's consultant for a urological problem. Patients were divided into 3 groups depending on the reason for consultation.

Results: In total, 1106 elderly patients between 50 and 75 years could benefit from this screening. The average age was 63.2 years. Our patients were distributed as follows: Group I (either 58% patient presenting with TUBA 641), II group or witness (409 patients either 37% consultant for a urological issue unrelated to the prostate), group III (56 patients summoned or at their initiative either 5%). The rectal touch suspected malignancy (11.5%). The PSA was high in 18.4% of cases. Biopsies were performed in 175 patients (15.8%). Prostate adenocarcinoma was found in 68 cases, giving a 38.9% for the whole of realized biopsies prostate cancer detection rate and a frequency of 6.1% of prostate cancer among all of our series of screening patients. A cure has been achieved in 29 patients with favourable evolution.

Conclusion: The individual screening of prostate cancer, based on the achievement of touching conclusion rectal and a determination of the Prostate Specific Antigen rate (PSA) annually, is currently the only way diagnostic for this type of cancer at an early stage suitable for a cure. We believe that there is no underestimation of total number of prostate as cancers suspect it of prior local studies.

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Comparison of Histological Results

Performed by Two Pathologists of Histoscanning-Guided Prostate-Biopsies

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Introduction and Objective: The detection rate of the prostate biopsy (PB) ranges from 20-30%. There are different factors playing a role in detection prostate carcinoma. First of all the digital rectal suspicious lesion or the suspect lesion in the transrectal ultrasound has to be unerring punctured. The pathologist needs sufficient material to perform a good histological report. A new technique for puncturing suspicious areas is the histoscanning-system, which analyzes a performed 3D-Picture based on an ultrasound investigation. Aim of this study was to compare the histological results from perineal histoscanning-guided PB analyzed by two pathologists.

Material and Methods: Between January and March 2011 we performed 43 PB. The indication for PB was a suspicious digital rectal palpable lesion, a PSA more than 4ng/ml or a raising PSA-Velocity. A histoscanning was performed preoperatively. Afterwards the suspicious areas were punctured in perineal guided-technique and sent to our department of pathology and to the reference pathologist.

Results: The mean PSA-Level was 6.8 ± 4.8 ng/ml and the mean prostate volume was 49.5 ± 26 ccm. Overall the pathologists detected in 8 of 20 biopsies (40%) a prostate carcinoma. In 5 of 8 cases the pathologists detected prostate carcinoma in different patients. Only in two cases the pathologists detected prostate carcinoma in the same patients. Additional one pathologist found 2 low-grade-PINs and the other detected 7 high-grade PINs.

Conclusion: The pathologists detected the same number of carcinomas. Only more than half of the cases the pathologist detected a carcinoma in different patients. Noticeable was the high number of high grade PIN's found by one pathologist. This was perhaps down to the fact that the PB was taken from minimal different localizations in small prostate cancer areas, the different working up of the probes or in individual assessment of the probes by the pathologists. Against this background, studies in prostate biopsies have to be evaluated critically.

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Histoscanning-Guided Prostate Biopsy in Comparison to a Systemic 14-Fold Transrectal Prostate Biopsy

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Introduction and Objective: The detection rate of the prostate biopsy (PB) ranges from 20-30%. Normally the PB is performed systemically. There are a lot of new imaging techniques for localizing prostate cancer. One of this techniques is histoscanning, an ultrasound based technique showing tumor-suspicious areas in the prostate. The aim of this study was to evaluate if a histoscanning-guided prostate biopsy can increase the detection rate of a carcinoma in comparison to a systemic 14-fold transrectal prostate biopsy.

Material and Methods: Between January and March 2011 we performed 43 PB.

The indication for PB was a suspicious digital rectal palpable lesion, a PSA more than 4ng/ml or a raising PSA-Velocity. A Histoscanning was performed preoperatively. The PB contains a 14-fold transrectal biopsy and afterwards a guided perineal biopsy for better guidance into the suspicious areas found in the histoscanning.

Results: Overall we detected in 16 of 43 (37%) PB, a prostate carcinoma. In the histoscanning-guide PB we found 9 out of 43 carcinomas and in the transrectal 14-fold biopsy we detected 10 out of 43 (23%) carcinomas. The mean number of the perineal biopsy cores were 8.2 cores per patient. In January we detected 27%, in February 29% and in March 75% carcinomas.

Conclusions: The detection rate of carcinomas in our clinic was high and the detection rates between the systemic transrectal and the guided perineal PB were comparable. The number of cores we needed to detect the carcinoma in the histoscanning-guided biopsy were much lower than the number of cores in the systemic transrectal biopsy. We detect four additional carcinomas out of 16 by performing the perineal histoscanning-guided biopsy. How far this increase is caused by the perineal technique, the histoscanning guided sample-taking and/or the increased number of cores taken has to be evaluate. The learning curve of the guided biopsy is short, which can be seen in the continuous increasing detection rates.