NDP022:
RETROPERITONEAL LAPAROSCOPIC RESECTION OF NEUROGENIC TUMOR

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Purpose: Retroperitoneal laparoscopic resection of retroperitoneal tumor can be challenging due to variations in location, size, and tumor characteristics. We would like to share our experience in retroperitoneoscopic surgery for neurogenic tumor and the experience of using intra-operative neuromonitoring technique.
Materials and Methods: Between June 2014 and December 2015, retroperitoneal laparoscopic resection of retroperitoneal tumor was performed on 10 patients. Three of the 10 patients were pathologically proved Shwannoma. Others include metastatic malignant melanoma, leiomyosarcoma, liposarcoma, cystic lymphangioma, hemangioma, adrenal cortical carcinoma, and pheochromocytoma. Among three patient with Shwannoma, intraoperative neuromonitoring was used in two patients for pre-operative image suggest possible neurogenic tumor. One patient underwent resection of two tumors at the same time.
Results: The median tumor diameter was 6.75 cm (range 4–12). The tumor location: two embedded on right psoas muscle with right L3 root compression, one at lower pole of right kidney with right psoas muscle adhesion, one at retrocaval region. All of the tumors were approached retroperitoneally. The median operative time was 206 min (range 120–300) and blood loss was 33 mL (range 0–100). No patient required blood transfusion. One patient receiving robotic assisted surgery had a conversion to traditional laparoscopic surgery because of malposition of the robot. Pathological examination revealed all schwannoma in 3 cases. During follow-up, there was no tumor recurrence noted.
Conclusion: Retroperitoneal laparoscopic resection of neurogenic tumor is a feasible choice. Combining intraoperative neuromoitoring, we can decrease the risk of neurological complication. When dealing with tumor next to great vessel or location hard to approach, pre-operative planning is necessary.

NDP023:
MULTILOCULAR CYSTIC NEPHROMA: A CASE REPORT AND REVIEW OF THE LITERATURE

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Cystic nephroma is a relative rare benign renal lesion with a bimodal age distribution. Diagnostic peaks occur primarily in the first 2 to 3 years of life, and again in the forty to fifty years. They are usually incidentally found as an asymptomatic abdominal mass. Radiologically, it is difficult to differentiate between cystic nephroma and cystic RCC in adults. The exact diagnosis primarily depends on the histopathologic examination. We present a 28 year-old male patient with a symptomatic, incidentally found left complicated renal cyst. A laparoscopic partial nephrectomy was performed on this patient. Microscopically, the tumor composed of variable-sized cysts lined by a layer of flattened or cuboidal cells with a confirmed histological diagnosis of cystic nephroma. The literatures were reviewed.

NDP024:
METANEPHRIC ADENOMA OF THE KIDNEY – A CASE REPORT AND LITERATURE REVIEW

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Purpose: Metanephric adenoma (MA) is a rare neoplasm. It's benign renal neoplasm originating in the epithelial cells of the kidney. Most tumors are asymptomatic, and incidentally discovered during examinations for other problems. It is difficult to distinguish metanephric adenoma from malignant neoplasms by image. It is often diagnosed by pathological report after surgical treatment. The present study reports the case of a 45-year-old female that presented with metanephric adenoma.
Materials and Methods: A 45 years-old female had small renal mass over left kidney during evaluation of pancreas mass. Physical examination revealed no significant finding. Computerized tomography (CT) and Magnetic resonance imaging (MRI) revealed a neoplasm lesion localized in the left kidney without lymphadenopathy. Left partial nephrectomy was performed on December 23, 2015. Microscopic finding composed of monotonous tumor cells with few light pink cytoplasm, small, uniform nuclei and inconspicuous nucleoli, arranged in solid sheets, small acini, and papillary structure. Hyalinized stroma with focal calcification are also noted. The tumor cells are immunoreactive for Wilms' tumor antigen (WT1). The final pathological report revealed metanephric adenoma.
Results: According the literature review, Metanephric adenoma (MA) is a rare benign tumor that accounts for 0.2–0.7% of adult renal epithelial neoplasms. <200 cases have been reported in the literature. Peak age of MA was in the fifth or sixth decade of life. Most tumors are incidentally finding. Some patient will have flank pain, hematuria and palpable mass. Lab data may reveal polycythemia. MA cannot be easily distinguished from other malignant neoplasms using imaging alone. Macroscopic, MA appears as a well-defined, round, solid, soft mass varying in size. Microscopic, MA expresses CK7 and WT1 and does not express epithelial membrane antigen or AMACR. Radical or partial nephrectomy may indicate for treatment due to the risk of malignancy without pathology.
Conclusion: Metanephric adenoma is a rare benign tumor. It cannot be easily distinguished from malignant neoplasms of kidney by imaging. Metanephric adenoma can recognized by microscopy. Surgical intervention is suggested due to diagnosis is challenging without pathology.

NDP025:
PRIMARY LARGE CELL NEUROENDOCRINE CARCINOMA OF THE KIDNEY WITH COEXISTING HIGH-GRADE UROTHELIAL CARCINOMA AND VIRCHOW'S NODE METASTASIS: A CASE REPORT AND LITERATURE REVIEW

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Primary large cell neuroendocrine carcinomas of the kidney are extremely rare, and distant metastases are scarcely reported. Here, we report a case of a 68-year-old man who presented with hematuria and was found to have an enlarged neck mass and a huge mass at the left kidney. Radical nephroureterectomy with bladder cuff excision and paraaortic lymphadenectomy was performed. A diagnosis of primary large cell neuroendocrine carcinoma with coexisting high-grade urothelial components was rendered. Besides, the fine-needle aspiration cytology reported neuroendocrine metastasis. In this report, the clinical, cytological, histological, and immunohistochemical features of this case are described, and a review of the literature about this neoplasm is presented.

NDP026:
MALIGNANT GLOMUS TUMOR OF KIDNEY – A CASE REPORT

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Purpose: Glomus tumors are mesenchymal neoplasms that resemble normal glomus body. Glomus tumors most often occurred in the

extremities, and rarely arise from visceral organ. Herein, we report a rare case of malignant glomus tumor arising from kidney.
Case report: A 46 years old man with history of nasopharynx cancer, status post chemoraiation therapy, has right renal tumor found incidentally on a pulmonary computed tomography scan for following of nasopharynx cancer. A contrast enhanced computed tomography of abdomen showed a tumor about 4.4cm with heterogenous enhancement over medial upper pole of right kidney. The patient undertook laparoscopic right radical nephrectomy with right adrenalectomy and recovered well after the operation. According to the histologic and immunohistochemical examination, the tumor is diagnosed as malignant glomus tumor.
Conclusion: Glomus tumors resemble glomus body, which is associated with body temperature regulation. Glomus tumors usually occur in the extremities, most common the subungual region of the fingers. Visceral organs are uncommon site involving development of glomus tumors. Glomus tumors arising from kidney are extremely rare, with a few cases described before.
It is difficult to differentiate glomus tumor from other renal malignany preoperatively through imaging study. Histolgoy and immunohistochemical study are necessary to make a diagnosis of glomus tumor of the kidney. Renal glomus tumors are usually benign with good outcome and prognosis, with one exception of malignant glomus tumor been reported. We report a case of malignant glomus tumor of kidney. To our knowledge, this is the second case of malignant renal glomus tumor reported. Given the small number of cases reported to date and relative short-term follow up, close clinical follow-up is necessary.

NDP027:
CANCER-TO-CANCER METASTASIS: BREAST CANCER METASTASIZED INTO RENAL CELL CARCINOMA – A CASE REPORT

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A 42-year-old female patient, a case of left breast mass with skin ulceration diagnosed by biopsy, was accidentally found to have right renal mass on CT (computerized tomography) during cancer staging workup. Metastases to axillary lymph nodes, bone and liver were also noted at the same time. Second opinion was sought from Urologist for the right renal mass while she underwent CCRT (combined chemo-radiotherapy). Biopsy of right renal mass revealed renal cell carcinoma (RCC) and radical nephrectomy was done 2 months after initial CCRT. Staging for the RCC was T1aN0M0 while breast cancer stage was T4N1M1.
There are 7 cases (including the current case) reported to have breast cancer metastasized into RCC. Their ages range from 42–75. Four of them have RCC on the same side as their breast cancers. Two of the cases are found only after autopsy. Time lapse in diagnosis of RCC after breast cancer is from one month to 30 years.
Less than 50 documented cases of cancer-to-cancer metastasis have been reported. RCC is the most common tumor found to coexist with other malignancies and is the recipient tumor in cancer-to-cancer metastasis in 65–75% of the reported cases. Because of the “terminal stages” when kidneys are involved in breast cancer patients, RCC may be underdiagnosed in these patients and cancer-to-cancer metastasis might be much more frequent.

NDP028:
UNUSUAL PRESENTATION OF DIRECT INTRA-PERITONEAL METASTASES COMPLICATED WITH MASSIVE ASCITES FROM POOR DIFFERENTIATION BLADDER TUMOR: A CASE REPORT

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Purpose: Plasmacytoid urothelial carcinoma variant is a rare histological finding, which was first described in 1991. Since then, only 70 cases have been described in the literature and the biological behavior of this variant of urothelial carcinoma is still not well known. The plasmacytoid variant is usually very aggressive; distant metastases are detected in up to 60 % of cases at the time of diagnosis with special predilection for dissemination through the fascia causing peritoneal carcinomatosis. Despite being a tumor of poor prognosis, it has been shown to be chemosensitive. This report describes a patient who have adenocarcinoma of colon and plasmacytoid urothelial carcinoma variant of bladder. Clinically mimicking a massive ascites and pitting edema of bilateral low legs without hematuria.
Case report: The 74-year-old male suffered from abdominal fullness and bilateral low legs edema in mid-Aug, 2015. He had visited our GU outpatient department and abdominal sonography was performed which revealed massive ascites. He was referred to our ER on 2015/08 and abdomen CT revealed three important finding (1) massive ascites and omental cake, (2) Enlarged nodes in the para-aortic space, (3) Diffuse irregular wall thickening in the urinary bladder, which suspected bladder. In ER, abdominal paracentesis was done and cytology was collected. After admission, tumor markers were checked and CEA elevated, so he was scheduled to receiving colonoscopy and one 3cm colon tumor was found at sigmoid colon and several small nodules over whole colon. He also received cystoscopy and non-papillary type bladder tumor was found. After colon tumor biopsy and transurethral resection of bladder tumor, we confirmed that the patient have double cancer. Ascites cytology suggested malignancy and peritoneal carcinomatosis cannot be rule out. We had used ascites immunohistochemistry method for search primary tumor. Usually, we think the origin is form the colon tumor. However, this is not what we think as a patient. The histological diagnosis of the tumor was plasmacytoid urothelial carcinoma variant of bladder with peritoneal metastasis. He was referred to oncology for further chemotherapy.
Conclusion: The plasmacytoid variant of urothelial carcinoma, defined as the presence of plasma cells similar to myeloma, has had an increase in prevalence in recent years, which has aided in increasing our understanding of its biological behavior and clinical implications. It is considered to be a type of carcinoma with an aggressive histological behavior with special predilection for local invasion of fascia and adjacent tissue. It also has a poor prognosis with a significant percentage of patients having metastases at diagnosis, especially intraperitoneal dissemination.

NDP029:
SALVAGE HIFU (HIGH-INTENSITY FOCUSED ULTRASOUND) IN THE MANAGEMENT OF PROSTATE RESIDUAL TUMOR AFTER PRIMARY HIFU

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Purpose: Recent data on the Ablatherm® HIFU device shows a 5-year biochemical disease-free survival rate of 80–85%. 15–20% patients have residual tumor when treated by HIFU for localized prostate cancer. HIFU can also be used as salvage therapy after radical prostatectomy and external-beam radiotherapy. There has been little or no literature about this novel use of secondary HIFU. We present our data of using secondary HIFU in the management of residual tumor after primary HIFU, with the aim of determining efficacy and safety of this modality.
Materials and Methods: A total of 168 patients underwent HIFU for primary treatment of localized prostate cancer from December 2009 to July 2015. 12 patients were offered HIFU as secondary salvage management. All of these had histologically proven residual/ recurrent prostate cancer after primary HIFU. 8 were given HIFU as the only management, 3 were given hormone therapy with HIFU, and 1 received HIFU, hormone therapy and radiotherapy.
Results: The mean pre-secondary HIFU PSA was 2.28 ng/ml (0.52–4.77). After salvage HIFU, 8 out of 12 patients (66.7%) achieved nadir PSA less than 50% of pre-treatment values. These showed biochemical disease free survival. Mean post-treatment nadir PSA value was 0.39 ng/ml (0.02–0.75). Time to achieve post-treatment PSA nadir was 1.13 months (1–2). The 8 patients had mean post-treatment PSA of 0.78 ng/ml (0.02–1.78) when followed up over a mean period of 11.25 months (1–20), demonstrating biochemical disease free survival.
3 patients (25%) had elevation of PSA, mean 5.6 ng/ml (3.17–7.52), after salvage HIFU. These were registered as failures. One patient was excluded from the study because of negative prostate biopsy, which meant that it could not be ascertained that the disease was localized or metastatic.