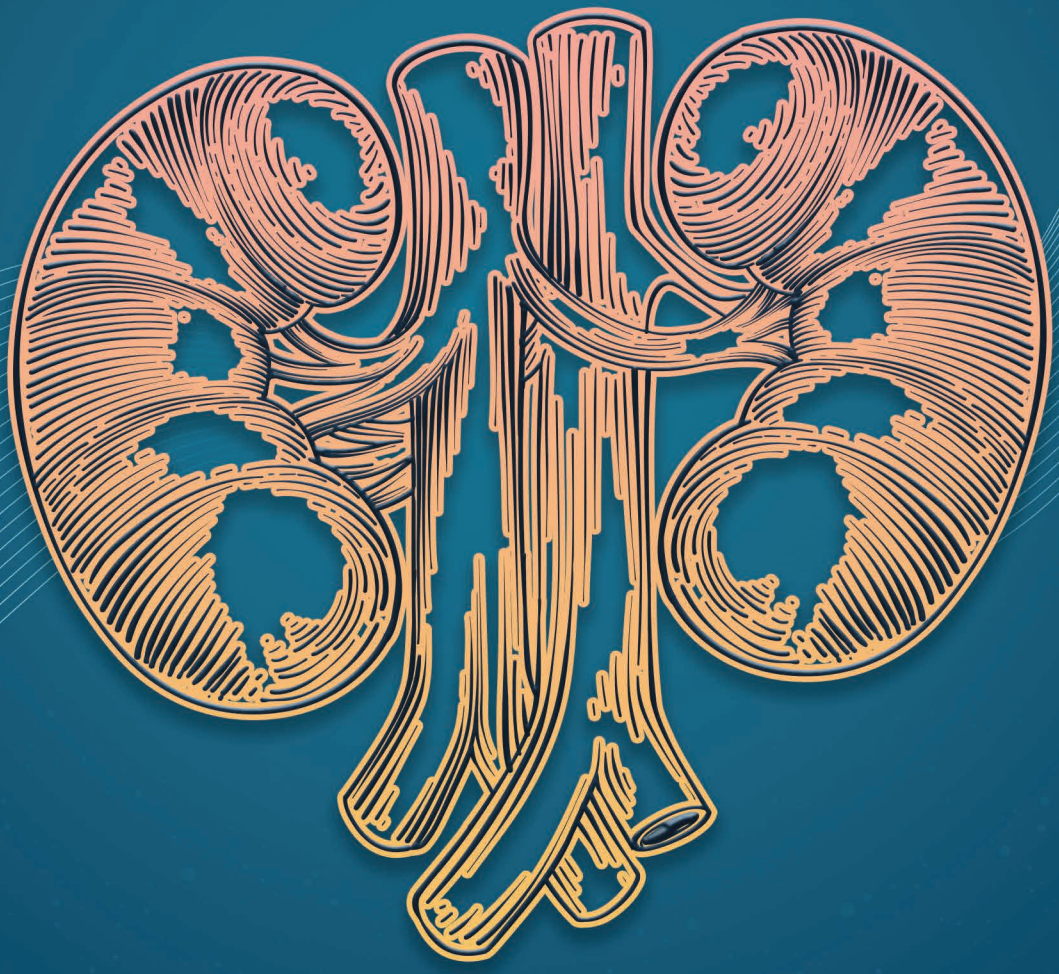
UROLOGICAL ASSOCIATION OF KERALA

NEWS LETTER



JUNE
2024

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Presidential Message



Dr Dineshan K M
President

Dear Friends

Greetings from Calicut!

The Mid-term Conference of UAK was conducted at Amirtha Hospital on 27th and 28th April 2024. The theme of the conference was Geriatric Urology and Men's Health. It was a very well-organized conference. The scientific deliberations also were excellent. It is very unfortunate that the attendance for the Mid-term conference was very poor. Since there were no papers and posters submitted for presentation, these sessions were cancelled. It is very distressing to find that not even a single poster or paper was submitted for presentation in spite of repeated reminders from the organizers.

This is probably the first time in the history of UAK that the sessions had to be cancelled due to non-submission of papers.

I request all the teaching as well as non-teaching institutions and all our members to take a serious note of this and participate regularly in the UAK activities. It was not long ago, that urologists from all over the country used to attend the UAK meetings to find out what are the recent developments happening in Urology in the country.

The UAK website is ready now. But here also the active participation of all the members are needed to make it informative and useful.

The organizers of Kollam UAKON has already started their preparations. I request all the members to actively participate in the scientific deliberations during the annual meeting.

Hope to meet you all at Kollam

with warm regards

Dr Dineshan K M
President UAK

Message from Hon. Secretary



Dr. Balagopal Nair T
Hon. Secretary

Dear Members;

Greetings to every one!

The midterm UAK workshop was held on 27 & 28 April 2024, at Amrita Institute of medical Sciences, Kochi. Led by Dr. Sanjeevan KV an interesting and interactive session on geriatric urology involving specialists from other specialties. A general body meeting was also held during the midterm workshop, details of same to be shared at the annual conference. The participation from UAK members was dismal probably due to prior commitments and lot of conferences taking place around the country.

The 38 annual UAK Conference is to be held in Kollam on 19 & 20 October 2024 at the picturesque Hotel Leela Ashtamudi Raviz. The organizing committee have started the preparation in full swing and have started registration process for same. It will be our endeavour to have a unique and informatics scientific event. Hope to see active participation from all member at Kollam.

Dear post graduates the topic for this years review article is Immune check point inhibitors in urological malignancy You can all start preparing for the same the last date for sub mission will be intimated soon through mail and WhatsApp I would like to take this opportunity to inform that only UAK members will be eligible for paper presentations in the annual and UAK CONFERENCE AT KOLLAM and also for the review article, So please kindly become a member

UAK's PG teaching program is continuing with active participation from both the faculty and the postgraduates monthly twice. The UAK as part of promoting leadership among its young members is planning a leadership seminar for the members on 25 August 2024. It is an effort to guide our members to be a part of either organizational or academic field as per their strengths at both zonal, national and international level. Stalwarts from our national body along with members from our association who have been active will be taking part.

Sincerely;

Dr Balagopal Nair T
Secretary
Urological association of Kerala

Message From Editorial Secretary



Dr. Joju Varghese Akkara
Editorial Secretary

From the Editors Desk

Dear UAK Members,

Greetings from Thrissur!

In this newsletter of June 2024 I have incorporated two good articles by Dr Ramaprasad and Dr Midhun Gopalakrishnan, excellent case report from AIMS Kochi by Dr. Mounish Nuthalapati and e-poster by Dr. Yensani Prasanth Reddy detailed reports and photos of Geriatric Urology conference conducted at AIMS Kochi and other features include Uro Quiz, Tips for common Urology Procedures, once again requesting all UAK Members to extend support by sending articles, case reports and other interesting urology scenarios.

With regards

Dr Joju Varghese Akkara
Editorial Secretary – UAK

Uro Quiz - Questions

1. Who first reported rapid dilation of the nephrostomy tract which revolutionized the percutaneous renal stone surgery?

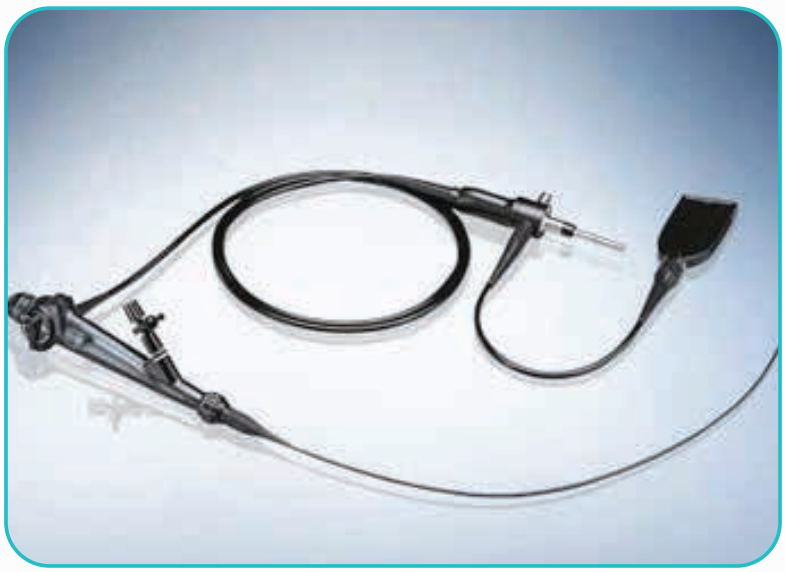
2. Who first reported use of first flexible ureteroscope with active and passive deflection?

Common Urology Procedures -

RIRS for Renal Stones

Steps

1.Preferably Pre-stent the Patient
2.Use general anesthesia with Neuro muscular block
3.RGP – Direct fluoroscopic guidance with water soluble contrast (Anatomic Road Map)
4.Two Safety Guide Wires into renal pelvis under fluoroscopy guidance
5.Ureteric Access sheath placed up to proximal ureter
6.Systematic inspection of calyces
7.RGP – through the Uretero renoscope for delineation of intrarenal anatomy
8.200-micron laser fiber preferably used
9.Relocate of stone to Upper Pole Calyx in case of Lower Pole Calculus
10.Inspection of entire PCS after stone fragmentation
11.UAS withdrawn along with Uretero renoscope
12.RGP – Followed by DJ Stent Placement



Verse- The Stone

Dr John Abraham
Consultant Urologist
Little Flower Hospital
Angamaly



A Sprightly young man was he
Became a pile of Agony

A stone came down
From his kidney
Blocking the tube below
Causing All this misery..

He yelled and screamed
As the pain came in waves
Wriggling and turning was he
As the pain Grasped him
And Gripped him..

Vomitus came out
Of his empty stomach
As the pain
Engulfed him

They sedated him
And Blocked his pain
Pushed down
Intravenous fluids
Down his veins

Drew his blood
For the reports
And Scanned his Tummy
To find the Offending Stone.

The good doctor
Came
And Screened the Stone
On the Computer Screen

"Will need a surgery "
said the Urology Man
With a comforting voice..

They wheeled him
To the Operating Room
Where
The Sleep masters
Took over
And
He dozed off
Without a fuss

The Angels
Got ready
With their Towels ,DrapesAnd
Scopes
And
A Team got ready
With The X-ray machine

The Stone hunter
Entered the scene
And surveyed the Damage
Caused by the stone
Peering through his Thin scope
Mirrored on a screen..

Passed a guide wire
Past the Stubborn Stone
Relieving the Agony
Of a suffering Kidney
A Stent was placed
And the deed was done..

As the poor man
Woke up to his senses
A radiant smile
Filled his face..
The pain and suffering had gone..

The surgeon ,He Was feeling Elated
As he saw the man's face
Knowing Fully well
That
He Was truly
An Instrument
In God's Healing hands..

Dr Ramaprasad M K
Endourology Unit, Department of Urology,
AsterMedcity,Kochi.



Article

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Endourology Unit, Department of Urology,
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Minimum intervention techniques for Benign Prostatic Obstruction: Our Experience with Urolift and Rezum.

Since time immemorial, Urology has been recognised as a separate speciality by the medical fraternity. The reason for such a separation is the peculiar nature of the prostate gland. This gland is situated in the depth of the pelvis which makes its access difficult. Also, the complications associated with interventions were serious enough to make it a dreaded nightmare among us. The renaissance in Europe provided the much needed technical breakthrough with the intervention of rod lens system and cold external light source. This paved the way to the gold standard treatment of BPO in the 20th century- Trans-urethral Resection of Prostate Gland or TURP. Open prostatectomy was quickly replaced by the endoscopic procedure by the millennial period. The scientific innovations fuelled by the downsides of TURP led to a myriad of alternative minimally invasive procedures for BPO by the Gen Z Period which continues till date.

What are the problems with TURP?
Bleeding risk especially associated with the use of antiplatelets, need of sterile water during surgery leading to fluid overload, electrolyte imbalance and hyponatremia, anaesthesia related effects etc are a few problems associated with TURP which can be life threatening. In addition to these, quality of life issues can arise after TURP due to absence of semen during ejaculation. Although rare, TURP can lead to urinary incontinence and urethral stricture. With a large gland, the resection can leave behind a significant amount of prostate tissue.

Many of these problems are tackled with techniques like Bipolar or LASER resection/ vapourisation. The two important additions in this direction include Rezum and Urolift. We would like to discuss our experience using Rezum and Urolift to treat BPO.

Urolift ™ is a retraction system for the bulging prostate lateral lobes.

Indication: We use this option for patients when there is minimal response to medical management in prostate glands less than 60 cc in size. Men who want to preserve the ejaculatory function can undergo this procedure.

Evaluation : A cystoscopy is done before deciding on the procedure to assess the lobes including the median lobe.

Advantages : It will not lead to urethral damage since the applicator is small in size(20Fr). There is minimal chance of bleeding or clot retention. We do the procedure in short GA/spinal anaesthetic block till date. There is no ejaculatory dysfunction associated with this procedure.

Procedure : The procedure is done using the Urolift device fitted with regular Zero Degree Hopkins rod lens Cystoscopy telescope.Depending on the length of the prostate,3-4 clips are deployed under vision. It is done away from internal and external urinary sphincters.

Outcome and follow up: we have done Urolift in 38 patients till 1st of May,2024 from 1st of May 2023.. Of these patients 30 had severe obstructive LUTs and 8 had AUR. The mean procedure duration is 20 minutes. The catheter is removed after 48 hours. Three patients had immediate urinary retention after catheter removal and needed catheter for prolonged duration. Of these, 2 patients had additional procedures done at 1 month due to persistent retention of urine.

Drawbacks and contraindications: As already noted this technique cannot be used in large glands with complications. A median lobe is a relative contraindication for the procedure.But there are reports of median lobe being treated with Urolift. In such cases proper identification of the lobe topography is of at most importance. This should be attempted only in high volume setup done by experienced surgeons.

TURP / HoLEP after Urolift: It is possible to do TURP / HoLEP in patients who have undergone Urolift. The clips get exposed during the resections and are removed under vision.

Rezum : Convective water vapour energy (WAVE) ablation: is an ablative method to treat BPO.

Indications: It is done in glands less than 80 cc in size. This procedure can be done in patients with median lobe. Another advantage is that this procedure can be done in patients on antiplatelet drugs. This is also a safe option for patients in whom prolonged anaesthesia is not indicated. Even Though, we do this procedure with patients under short GA or spinal anaesthetic block,it can be done under periprostatic block or even in local anaesthesia.

Evaluation: A cystoscopy is indicated since the lobar morphology may alter the choice of the procedure and to plan the number of water vapour actuation doses.

Procedure: is done using the Rezum device supplied by the company. It is intended to be single use. A maximum of 15 applications are possible with a single device. An average of 5-6 applications are used in most of the patients. The Rezum applicator is of small size(20Fr) and is less damaging to the urethra.

Outcome and follow up: We have done Rezum in 46 patients starting from November of 2023. All the patients had severe LUTs as indication for Rezum. All the patients have shown significant improvement in symptom score and Qmax after Rezum at 1 month post operative period. One of the patients needed 2 weeks of catheter due to urinary retention. The post procedure catheter duration was 1 week while the number of Rezum applications was more than 5 and 4 days for smaller glands.

Drawbacks and contraindications: Longer catheter duration and resorption period of the prostate leading to gradually increasing flow which may take months to reach to the maximum. The maximum resorption occurs at 3 months post procedure.

Conclusion : The Urolift and Rezum procedures have a place in the modern management of BPO if applied cautiously. With the advancements in healthcare, more and more men are concerned about the effect of BPO management on sex life. Also, there are many men on multiple antiplatelet/ anticoagulant therapy these days. The newer minimal treatment approaches will help Urologists to address these issues in a meaningful manner.

Article

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INTRA VESICAL SEQUENTIAL GEMCITABINE DOCETAXEL CHEMOTHERAPY

INTRODUCTION

Urinary bladder cancer accounts for 3 % of global cancer diagnosis1. Some types of urinary bladder cancers are notorious for local recurrence and some others may progress to invasive cancer. It was in this scenario adjuvant intravesical therapy after TURBT gained significance. The role of onco BCG as adjuvant intravesical therapy in high grade lesions and single instillation of mitomycin C in low grade disease are established ones in management of non muscle invasive bladder cancer (NMIBC) now. One among the recent addition to the armamentarium of uro-oncologists in management of NMIBC is intra vesical sequential gemcitabine and docetaxel chemotherapy.

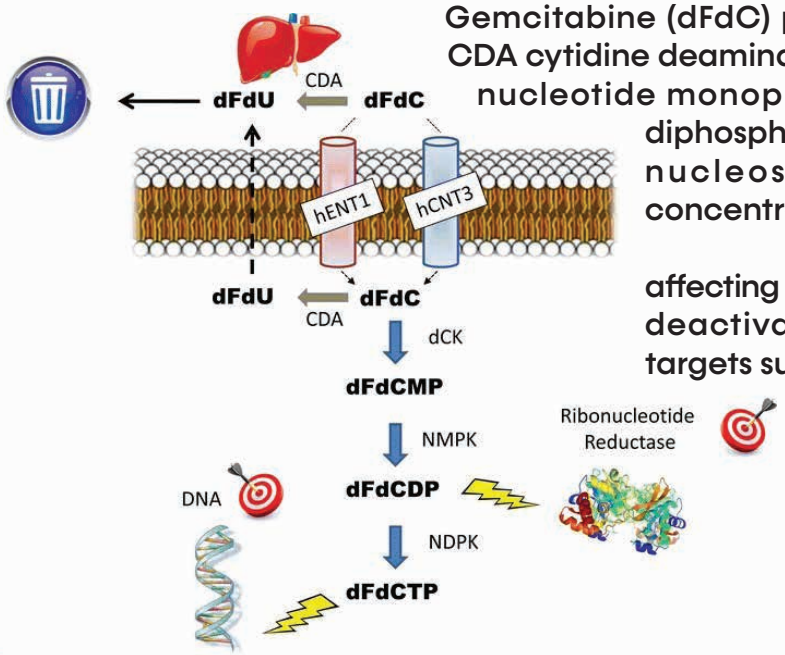
HISTORY

Gemcitabine was first synthesized in Larry Hertel's lab at Eli Lilly and company during the early 1980s and was intended as an antiviral drug initially. In 1998 gemcitabine received FDA approval for treating non-small cell lung cancer. Docetaxel was patented in 1986 and approved for medical use in 1995. Efficacy of sequential intravesical gemcitabine and docetaxel (Gem/Doce) for BCG failure was established in 2015 and has subsequently been reproduced across multiple institutions2. During covid pandemic time due to BCG shortage, sequential intravesical Gem/Doce was increasingly utilized as first-line adjuvant treatment for patients with high risk non muscle invasive bladder cancer.

MECHANISM OF ACTION OF THESE CHEMOTHERAPEUTIC DRUGS

Gemcitabine

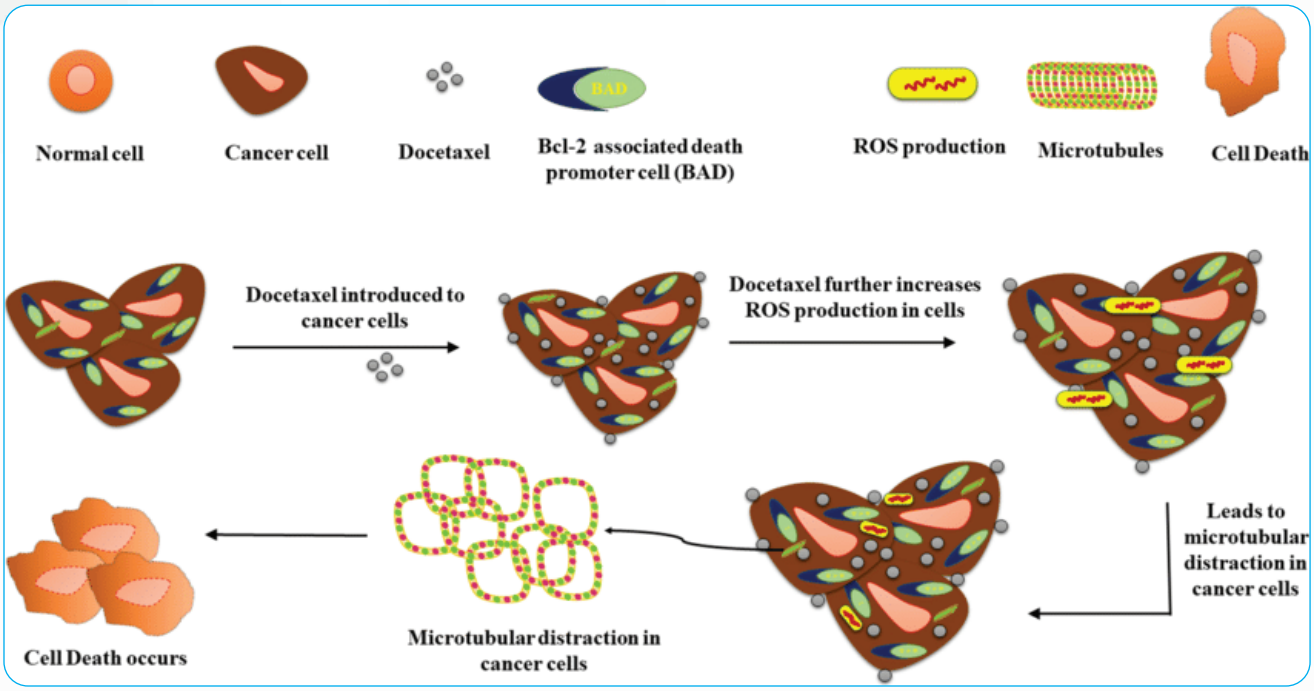
Gemcitabine exerts its antiproliferative action after tumoral conversion in to active triphosphorylated nucleotides interfering with DNA synthesis and targeting ribonucleotide reductase.



Gemcitabine (dFdC) patterns and mechanisms of action. CDA cytidine deaminase, dCK deoxycytidine kinase, NMPK nucleotide monophosphate kinase, NDPK nucleotide diphosphate kinase, hENT1 human equilibrative nucleoside transporter-1, hCNT3 human concentrative nucleoside transporter-3.

In cancer cells, genetic polymorphisms affecting membrane transporters, activating and deactivating enzymes and pharmacological targets such as ribonucleotide reductase, are all associated with treatment efficacy.

Docetaxel have a two fold mechanism of antineoplastic activity; inhibition of microtubular depolymerization and attenuation of the effects of bcl-2 and bcl-xL gene expression. Taxane-induced microtubule stabilization arrests cells in the G2M phase of the cell cycle and induces bcl-2 phosphorylation, thereby promoting a cascade of events that ultimately leads to apoptotic cell death.



Mechanism of action of docetaxel against cancer cells. Docetaxel introduced to cancer cells increases the production of reactive oxygen species and also brings about phosphorylation of BCL-2 BAD protein. This results in microtubular distraction leading to cancer cell death

INDICATIONS FOR SEQUENTIAL INTRAVESICAL GEMCITABINE DOCETAXEL CHEMOTHERAPY

- BCG failure
- High grade NMIBC when BCG is not available in market (as in covid times)

HOW TO INSTILL SEQUENTIAL INTRAVESICAL GEMCITABINE DOCETAXEL CHEMOTHERAPY

Prior to all instillations patients were treated with 1000mg oral sodium bicarbonate in the evening prior and the morning of treatment to alkalinize their urine. Alkalinization is thought to prevent some of the side effects of the acidic gemcitabine (pH 2.5). After complete bladder drainage 1 g of gemcitabine in 50 mL of normal saline instilled into the bladder for approximately 90 minutes. Subsequently bladder is emptied by voiding or by tube drainage. This is followed by 37.5 mg of docetaxel in 50 mL of saline for 120 minutes. But in market only 40 mg of docetaxel is available.

DOSAGE SCHEDULE AND SURVEILLANCE

This induction regimen was administered weekly for 6 weeks. Surveillance was initiated 4 to 8 weeks after beginning Gem/Doce with cystoscopy and urine cytology. If disease free at the first surveillance visit, monthly maintenance therapy is initiated for up to 24 months using the same protocol. Surveillance cystoscopy with bladder cytology was subsequently performed at 3 month intervals for 2 years and then 6 month intervals if disease free beyond 2 years.
Patients with low grade recurrence should undergo repeat TURBT and should be considered for continued maintenance with Gem / Doce.
High grade recurrence is considered as failure and need to be managed accordingly as per stage of disease. Treatment success of Gem/Doce was 66% at first surveillance, 54% at 1 year and 34% at 2 years after initiating induction. BCG has had 1-year recurrence free rates of approximately 70%, decreasing to approximately 60% at 2 years.

COMPLICATIONS OF SEQUENTIAL INTRAVESICAL GEMCITABINE DOCETAXEL CHEMOTHERAPY

- Storage symptoms - the most common
- Hematuria
- Chemical cystitis
- Cutaneous desquamation on contact with skin
- Decreased bladder capacity as a result of contractures

CONCLUSION

In conclusion, sequential use of intravesical Gem/Doce in the treatment of NMIBC in patients with prior BCG failures is definitely a useful addition in to uro-oncologist's armamentarium and it has demonstrated reasonable efficacy and tolerability in a difficult to treat population.

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Case Report



Dr Mounish Nuthalapati
M.Ch Resident
Department of Urology
Amrita institute of medical sciences
Kochi

Title - **"Palliative Nephrectomy Unveils IgG4 Disease: A Case of Mistaken Malignancy"**

Authors - Mounish Nuthalapati, Prashanth Reddy, Rohan Rajendran, Kannan Nair, Georgie Mathew, K.V. Sanjeevan
Department of Urology, Amrita Institute of Medical Sciences, Kochi, Kerala

Introduction

Immunoglobulin G4-related disease (IgG4-RD) was first described in 2001 as a causative factor in autoimmune pancreatitis. Since then, it has been found to impact various organ systems such as the pancreas, biliary ducts, salivary glands, ocular system, and lymph nodes.1 However, the involvement of the urinary tract and its presentation to urologists remain uncommon, with only a sparse number of published case reports to date.2 Here, we report a case of bilateral renal pelvic mass in which a nephrectomy was performed with palliative intent, but the pathology later revealed it to be IgG4-RD.

Case Report

A 60-year-old gentleman, diabetic and hypertensive, presented to the Emergency Department with complaints of left loin pain persisting for 5 days, worsening over the last 24 hours. He (Figure 1) reported experiencing a similar, albeit less intense, pain episode three years ago. During that episode, bilateral renal pelvic masses with left gross hydronephrosis, and enlarged paraaortic, interaortocaval, and retrocaval nodes were detected on imaging, which were found to be FDG avid on PET-CT done elsewhere. He was told these findings were indicative of malignancy, prompting discussions regarding radical surgery or chemoradiotherapy. However, the patient's pain subsided with antibiotics and analgesics, and he later pursued alternative non-allopathic therapies (Siddha) for a few days. Being asymptomatic for the past three years, he did not seek further medical attention during this period.

Upon evaluation at our facility, blood investigations revealed elevated inflammatory markers, while an in-house computed tomography (CT) scan (Figure 1) revealed bilateral renal pelvic masses of similar sizes as of three years ago, exacerbation of left hydronephrosis, and the presence of a new 9 mm liver nodule. Given the persistence of intractable pain, gross left hydronephrosis with thinned-out parenchyma, and elevated inflammatory markers, the decision was made to proceed with an emergency laparoscopic left palliative nephrectomy. Intraoperatively, dense adhesion of the renal hilum to the aorta and the upper pole to the spleen was noted, which was separated with difficulty (Figure 2). The gross specimen showed a yellowish-white solid-looking lesion filling the pelvis with thinned out renal parenchyma (Figure 3).

The final histopathology revealed an inflammatory lesion with storiform fibrosis and infiltration with IgG4-positive plasma cells (Figure 4). Further assessment revealed serum IgG4 levels measuring 3.47 g/L (normal range: 0.1 g/L - 2.5 g/L). A rheumatologist was consulted, and the patient was started on steroids during follow-up. At the 3-month follow-up, the patient was asymptomatic, with normal renal function tests.

Discussion

IgG4-related disease (IgG4-RD) typically induces inflammation and fibrosis, characterized by IgG4-positive plasma cell infiltration in affected organs, often accompanied by elevated serum IgG4 concentrations. Its tendency to form tumefactive lesions when localized to an organ can lead to misdiagnosis as malignant lesions. The involvement of the urinary tract and its presentation to urologists remain uncommon. Typical presentations to urologists involve renal pelvic or ureteric masses, which often masquerade as malignancies on imaging and are solely identified through histopathology following surgical intervention. Hyper-immunoglobulinemia is an important finding in these patients, but up to 20%–30% of patients have normal IgG levels.

Although surgery was deemed appropriate in our case based on the patient's presentation, an early diagnosis of IgG4-RD could have prevented the unnecessary emergency nephrectomy. In 2011, two distinct research teams led by Umehara and Okazaki,4 under Japan's Ministry of Health, Labour, and Welfare, established definitive diagnostic criteria for IgG4-RD, which include:

1. Clinical examination showing characteristic diffuse or localized swelling or masses in one or multiple organs;
2. Hematological examination showing elevated serum IgG4 concentrations (≥135 mg/dL);
3. Histopathological examination showing (a) marked lymphocyte and plasmacyte infiltration and fibrosis, and (b) infiltration of IgG4+ plasma cells with a ratio of IgG4+/IgG+ cells >40% and >10 IgG4+ plasma cells/HPF .

However, there are no criteria for a preoperative diagnosis without histological evidence. This case highlights the debate on the necessity of mandatory preoperative biopsies for suspected upper tract urothelial carcinoma, given EAU guidelines supporting upfront radical nephroureterectomy in high-risk cases.5 Ureteroscopic biopsy is hampered by inadequate tissue sampling, 15% false-negative rate, 11% incomplete reports lacking grade information, and significant discrepancies in grade compared to the final histopathology.6 Thus, extensive prospective research is necessary to devise aproaches for preoperatively identifying and managing IgG4-RD cases presenting as renal pelvic masses.

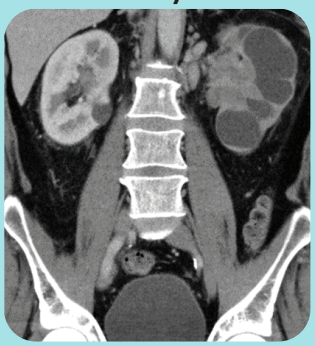
Conclusion

In summary, the manifestation of IgG4-RD as a renal pelvic mass is a rare occurrence, and its accurate preoperative diagnosis remains elusive. Nonetheless, ensuring a definitive diagnosis before surgery holds the potential to spare patients from unnecessary operative procedures. Hence, there is a pressing need for larger prospective studies aimed at devising comprehensive strategies for the diagnosis, treatment, and follow-up of IgG4-RD cases presenting as renal pelvic pseudotumors.

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Figure 1.
CT Scan shown bilateral renal mass, gross left hydronephrosis with extremely thinned out parenchyma



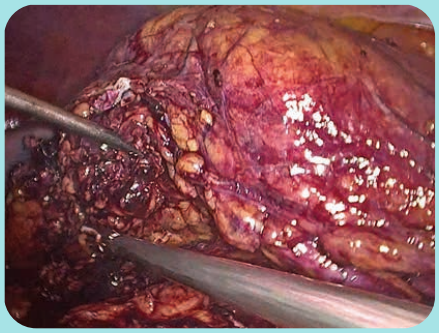


Figure 2.
Nephrectomy specimen in IgG4 related disease released from the surrounding adhesions



Figure 3.
Section through the nephrectomy specimen showing a yellowish-white solid-looking lesion filling the renal pelvis with thinned out parenchyma

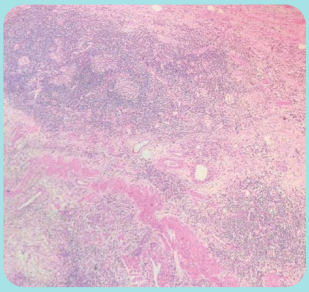


Figure 4.
Histopathology of the IgG4 related disease of the kidney showing inflammatory lesion with storiform fibrosis and infiltration with IgG4-positive plasmacells

Case Report

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Amrita Institute of Medical Sciences, Kochi



PRIMARY GLOMUS TUMOUR OF KIDNEY-A REPORT OF 2 CASES

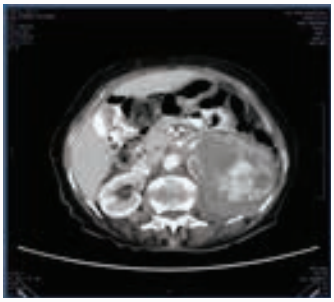
Dr. Yensani Prasanth Reddy, Dr. K V Sanjeevan, Dr Kannan R Nair, Dr Midhun Mohan
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INTRODUCTION

Glomus tumours are benign mesenchymal neoplasms arising from thermoregulatory glomus bodies. First described in 1924 by Masson Account for less than 2% of all soft tissue tumours A quarter of these are found in-visceral organs not expressing glomus bodies.
10% of glomus tumours are multiple, occasionally familial Sex distribution is equal, most occur during adult lifespan (20-40years)

CASE–1

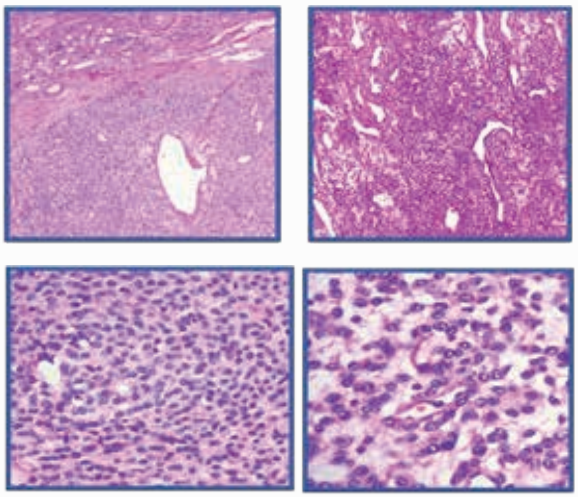
•77years old female
•Left side abdominal pain
•P/A-soft,vague10x8cm mass palpable in the left loin
•USG outside-left kidney exophyticmass with aneurysm
•CT-heterogeneously enhancing exophytic lesion arising from upper pole of left kidney
•Left open radical nephrectomy; size:7.5x7x7 cm



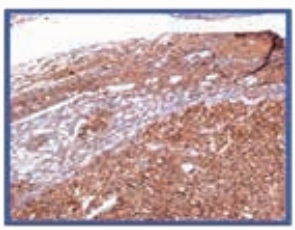
GROSS

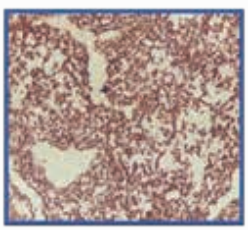


•The upper pole and interpolar area is replaced by tumour which is soft inconsistency with grey brown and hemorrhagic areas



MICROSCOPY–H&E





IMMUNOHISTOCHEMISTRY

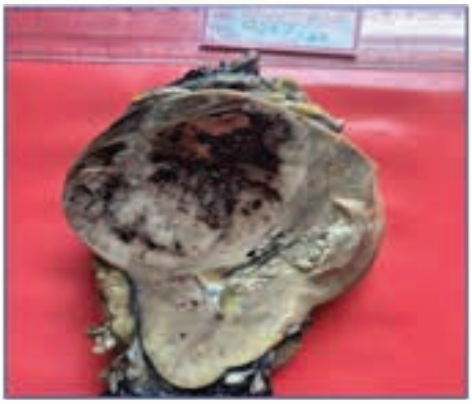
CK7,CD10,c-KIT,HMB45,
Synaptophysin–NegativeSMA, BCL2–Positive
Ki67:4-5%

DIAGNOSIS : GLOMUS TUMOUR OF UNCERTAIN MALIGNANT POTENTIAL

CASE–2

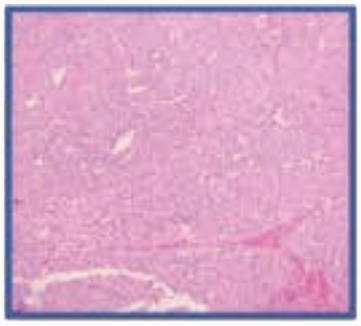
•50 yearsoldmale
•Pain abdomen and pedal oedema
•P/A-soft, nontender
•CT outside-solid heterogenous mass in cortexof left kidney
•USG-well defined heteroechoic mass in upper pole of left kidney

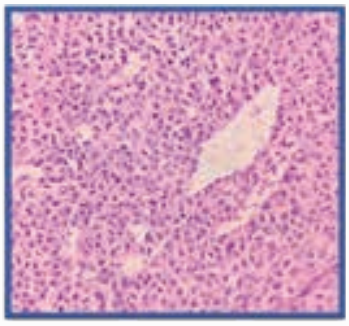
GROSS



•Left radical nephrectomy; size 9x8x6.8cms
•Well circumscribed, unencapsulated, tan-brown,firm tumour with hemorrhagic areas in interpolar area and abutting renal capsule

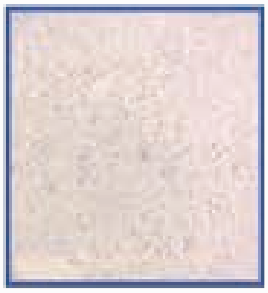
MICROSCOPY–H&E





IMMUNOHISTOCHEMISTRY





CK7,CD10,c-KIT,Synaptophysin,
BCL2–Negative SMA,
Vimentin– Positive
Ki67:3-5%

DIAGNOSIS: GLOMUS TUMOUR OF UNCERTAIN MALIGNANT POTENTIAL

DISCUSSION

- Primary renal glomus tumours are rare. Accurate diagnosisis based on the micro scopic appearance and characteristic immuness phenotype
- Glomus tumours in kidney is categorisedas
  - -Benign
  - -Glomus tumour of uncertain malignant potential
  - -Malignant glomus tumour
- Composed of modified perivascular smooth muscle cells arranged in sheets and nests with variably sized vessels
- Cells have round and epithelioid appearance
- Cells do not express any epithelialorendothelial markers
- Cells show prominent staining with smooth muscle act in
- Criteria formalignancy
  - -Deep location
  - -Size larger than 2cm
  - -A typical mitotic figures
  - -Moderate to high grade nuclearatypia
  - -5 or more mitosesper 50hpf
- Uncertain malignant potential - Glomus tumours not fulfilling the criteria formalig nancy but having at least one atypical feature other than nuclear pleomorphism
- Markers that predict malignant behaviour - overexpressionofBCL2,Ki67,p53

DIFFERENTIAL DIAGNOSIS

- Solitary fibrous tumour, myopericytoma, paraganglioma, angiomyolipoma, renal hemangioma,juxtaglomerular cell tumour, carcinoidtumour, and lymphoma.
- Less likely differential diagnosis include Ewing sarcoma, leiomyoma, andrenal cell carcinoma

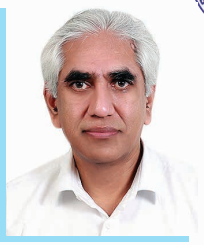
CONCLUSION

- Primary renal glomus tumours are rare and may mimic other mesenchymal renal neoplasms radiologically
- Furthermore, histological and immunochemical findings in glomustumours overlap with those of other kidney tumours and may contribute to an inaccurate diagnosis
- Proper investigation (including histopathological analysis and immunohistochemi calstaining)is essential to make the diagnosis of glomus tumours
- There are only a few reported cases of glomus tumours of kidney
- Overall prognosisis good
- Criteria associated with aggression among soft tissue pericytictumours may not be predictive for those in the kidney
- Diagnosis of uncertain malignant potential warrants for a frequent and close fol lowup

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Report on the Geriatric Urology Conference at Amrita Institute of Medical Sciences, Kochi

The Geriatric Urology Conference, hosted by the Department of Urology at the Amrita Institute of Medical Sciences, Kochi, on behalf of the Urological Association of Kerala Mid-Term Conference 2024, proved to be a significant gathering of medical professionals dedicated to the care of elderly patients with urological conditions. Held on the 27th and 28th of April 2024, the conference drew participation from approximately 65 doctors, primarily comprising urologists. Also in attendance were a select group of geriatricians, anaesthetists, intensive care physicians, and pain and palliative care physicians, along with faculty and trainees.

The inauguration of the conference was marked by a solemn invocation delivered by Swami Swamsidhamrita, AIMS Campus Director, followed by the formal inauguration by Dr. Gireesh Kumar K P, Principal, Amrita School of Medicine. The event was graced by the esteemed presence of Dr. Dineshan K M, President, UAK, who delivered the Presidential Address, setting the tone for the conference proceedings.

An important aspect of the inaugural function was the felicitation of eminent figures in the field of urology, namely Professor Sasidharan, Dr. Col Raveendran Nair and Professor Appu Thomas, revered elders and teachers whose invaluable contributions have significantly enriched the domain of urological care. The luminaries shared their "Pearls of Wisdom," drawing from their vast reservoirs of experience in urology, thereby imparting invaluable insights to the attendees.

The conference, structured around the theme of geriatric urology, encompassed a diverse range of topics, including but not limited to, the management of urinary incontinence, urinary tract infections, benign prostatic hyperplasia, urological malignancies in the elderly, nocturnal polyuria, sexuality among the elderly, urology among the nursing home residents, end of the life care and considerations for surgical interventions in geriatric patients.

Through a series of keynote addresses, panel discussions, and interactive case discussions, participants had the opportunity to delve into the nuances of geriatric urological care, exchange ideas, and engage in collaborative learning.

Noteworthy highlights of the conference included:

1. **Keynote Addresses :** Day 1 - **Fundamentals of Perioperative Geriatric Urology:** Experts in the field delivered keynote addresses, shedding light on the latest advancements and best practices in geriatric urology. Collectively, the keynote addresses delivered by Dr. Georgie Mathew (Urology), Dr. Midhun Mohan (Urology), Dr. Rekha Varghese (Anaesthesia/Intensive Care), Dr. Divyamol Sasidharan (Geriatrics) and Dr. Shyam Sundar (Anaesthesia/Intensive Care) illuminated the multifaceted challenges and opportunities inherent in perioperative optimization for the elderly population in the context of geriatric urology. By synthesizing insights from urology, anaesthesia, intensive care, and geriatrics, these experts underscored the importance of a multidisciplinary approach in ensuring the highest standards of care for elderly patients undergoing urological procedures.

2. Day 2 - **Urological problems of Nursing Home Residents, and End of Life Care considerations:** Dr. Sanjeevan KV (Urology) and Dr. Shobha Nair (Pain and Palliative Care Medicine) provided attendees with valuable insights into the urological challenges faced by nursing home residents and the nuanced considerations surrounding end-of-life care in the context of geriatric urology. By addressing these complex topics, they likely encouraged attendees to adopt a holistic and compassionate approach to caring for elderly patients with urological problems, particularly in settings such as nursing homes where specialized care and support are essential.

Panel Discussions: Thought-provoking panel discussions provided a platform for in-depth exploration of pertinent issues and challenges encountered in the management of geriatric urological conditions.

Day 1

1. UTI among the elderly: Dr. Nebu Isac Mamm (Urology) moderated the discussions on UTI in different circumstances. The panellists included Dr. Anilkumar (Clinical Microbiologist), Dr. Suresh Bhat (Urologist), Kottayam, Dr. Dipu T S (ID Specialist), Dr. Zubair Umer Mohamed (Intensivist), Dr. Rajesh R Nair (Nephrologist) and Dr. Divyamol Sasidharan (Geriatrician).
2. Dysfunctional Voiding and Incontinence among Elderly Females: Dr. Keshavamurthy R and Dr. Biju K R chaired the session and along with them, Dr. Dineshan K M, Dr. Jithunath M R, Dr. Joju Varghese Akkara and Dr. Sanjeevan K V spoke on the various aspects of female voiding dysfunction and urinary incontinence among the elderlies.
3. Genitourinary Oncology among the elderly: Dr. Arun Ramdas Menon moderated the panel discussions on the challenging urological cancers among the aged population along with the medical, radiation and uro-oncologists, Dr. Nikhil Haridas, Dr. Haridas, Dr. Suresh Bhat and Dr. Ginilkumar P.
4. Dysfunctional voiding among the elderly men: Dr. Sreerag KS, Dr. Rohan Rajendran and Dr. Vishnu Raveendran talked on the challenges and evaluation of the elderly men with voiding dysfunction. The talks were followed by case based discussions.
5. **Nocturia and Nocturnal Polyuria** : Dr. Kannan enlightened the audience regarding the gravity of the situation, its pathophysiology and management. Whether a healthy elderly person has to restrict fluid intake to quench the thirst only or has to take more was debated by Dr. Anil Mathew (Nephrologist) and Dr. Saraf Udit Umesh (Neurologist) with strong arguments for both views.

Day 2

6. **Video session on Minimally Invasive Procedures for Bladder Outlet Obstruction:** Dr. Rohan Raveendran presented the talk on various minimally invasive for the bladder outlet obstruction suitable for the elderly population. Allium Prostatic/Urethral Stents; UroLift; RezūmTM; Prostatic Artery Embolisation were discussed which all can be applied with minimal surgical risk.
7. **Geriatric Andrology - Sexuality among the elderly:** Dr. Vinod KV led the panel discussion with panelists Dr. Aravind G Ganapath, Dr. Manoj Kumar, Dr. Ramaprasad MK and Dr. Nithya R covering the androgen deficiency, erectile dysfunction, ejaculatory dysfunction and female sexual dysfunction.

Closing Ceremony :

As the second day drew to a close, attendees gathered for the final proceedings, which commenced with a Vote of Thanks extended to all participants, speakers, sponsors, and organizers who contributed to the success of the event.

Following the Vote of Thanks, the gathering stood united in harmony as the strains of the National Anthem reverberated. The distribution of participation certificates and lunch added a nice touch to the closing proceedings.

Overall, the Geriatric Urology Conference at Amrita Institute of Medical Sciences served as a valuable forum for fostering collaboration, sharing expertise, and advancing the collective understanding of urological care in the elderly population. The event undoubtedly left an indelible mark on the attendees, empowering them with the knowledge and tools necessary to deliver optimal care to elderly patients with urological conditions.

Department of Urology

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Unit I (OP: Wed / Fri)
Prof. Appu Thomas, MS, MCh (Urol)
Prof. Georgie Mathew, MS, MCh (Urol)
Asst. Prof. Rohan Rajendran MS,DrNB(urol), Mch (Urol)

Unit II (OP: Mon / Thurs)
Prof. Sanjeevan K. V MS, MCh (Urol)
Assoc. Prof. Kannan R Nair MS,DrNB,M-RCS(Ed), MCh, FRCS (Urol)
Asst. Prof. Midhun Mohan MS, MCh

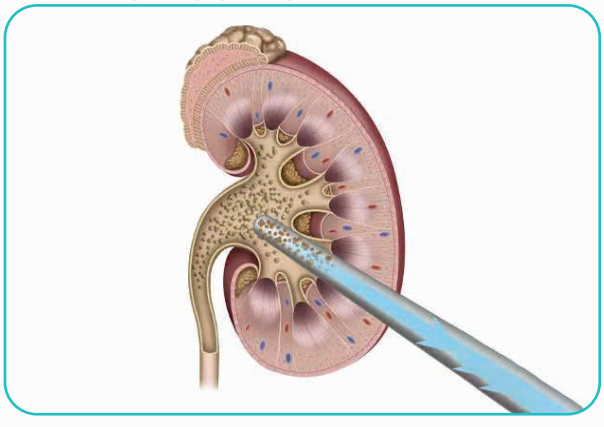
Uro-Oncology
Prof. Ginil Kumar, MS, Mch(urol), DrNB(Urol), MNAMS
Asso.Prof Dr. Arun Ramdas Menon, MCh (Urol),DrNB (Urol)
Fellow: Dr. T Nazareth Solomon, MS, M.Ch
Fellow: Dr. Shashank Agrawal MS, DrNB(Urol)

Registrars

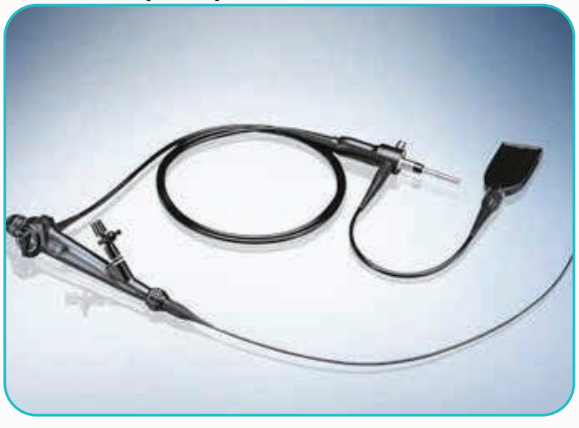
Dr. Owais Patel MS, [MCh Resident]
Dr. Nikhil MS, [MCh Resident]
Dr. Sanchit Mittal [MCh Resident]
Dr. Heet Jitendra Amlani[MCh Resident]
Dr. Mounish MS, [MCh Resident]
Dr. Krishnakanth MS, [MCh Resident]
Dr. Prasanth MS, [MCh Resident]
Dr. Vivek Patil MS, [MCh Resident]
Dr. Brahampreet Singh Kang [MCh Resident]

Uro Quiz - Answers

1. Smith (etal) (1982)



2.Grasso (1994)






UROLOGICAL ASSOCIATION OF KERALA
MID-TERM CONFERENCE 2024




Urological issues among the Nursing / Home Residents






Urology, AIMS Kochi


AMRITA HOSPITAL
UROLOGICAL ASSOCIATION OF KERALA MID-TERM CONFERENCE 2024






GERIATRIC
& MEN'S HI

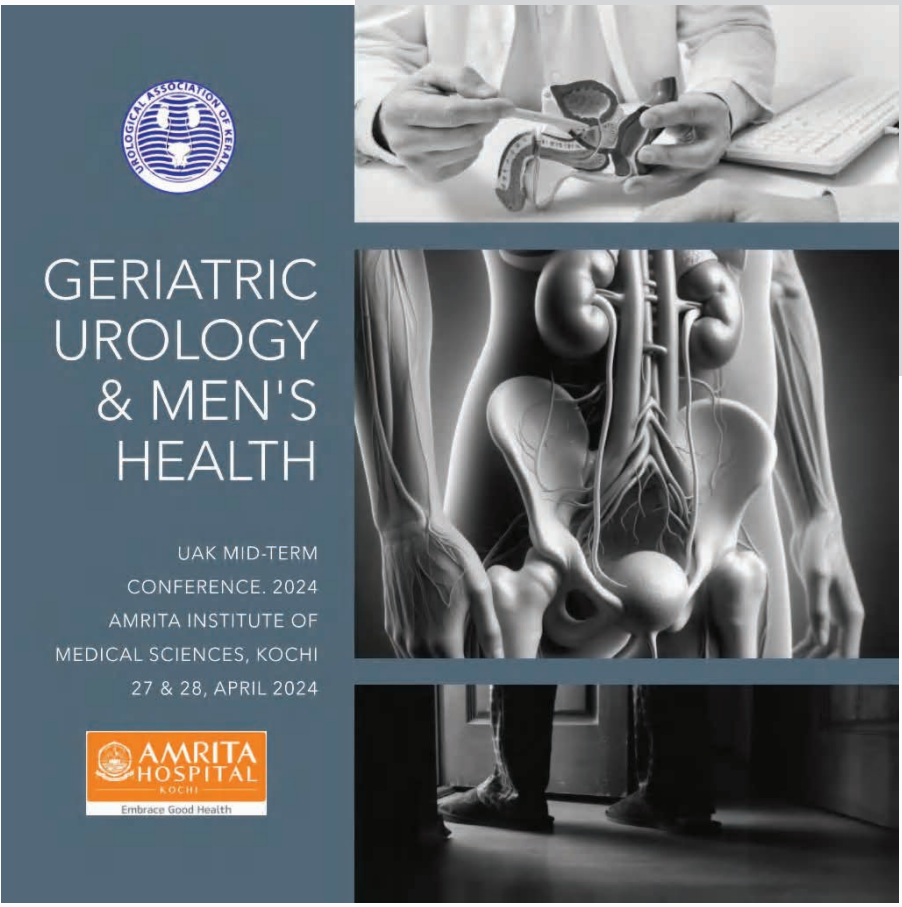







Urological issues among the Nursing / Home Residents


Urological Cancers among the Older Adults
Urological issues among the Nursing / Home Residents
UROLOGICAL ASSOCIATION OF
MID-TERM CONFERENCE 2024


GERIATRIC
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Forthcoming Events







