UROLOGICAL ASSOCIATION OF KERALA

NEWS LETTER



NOVEMBER

2024

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Dr. Sunil Jacob
Dr. N K Sanil Kumar

Presidential Message



Dr Vinod K V
President – UAK

Dear Members,

I am deeply honoured to have been given the opportunity to serve as President of the Urological Association of Kerala (UAK), India's oldest state urological association with a proud and distinguished history.
It is a privilege to lead an organisation that has long been at the forefront of urological advancement in our country, and I look forward to working with each of you to continue this legacy of excellence As we move forward together, I am excited to share our vision for building a stronger, more vibrant association that not only upholds our commitment to scientific excellence but also empowers our members to lead in clinical practice, research, and organizational innovation. This vision is rooted in a few key objectives that we believe will help us advance both as individuals and as a collective body.

Strengthening the UAK Office

To enhance our efficiency and allow us to concentrate on our core objectives, it is essential to establish a robust office team dedicated to managing routine administrative tasks. This will enable us to focus our efforts on advancing the scientific and clinical priorities that matter most to our association and its members. Adopting this approach allows us to better serve you, our members, and to ensure that UAK's work is meaningful and impactful.

Encouraging Leadership from Youth

Our young members represent the future of urology in Kerala. By involving them more actively in UAK's activities, we aim to foster a generation of leaders who are both innovative and dedicated. We will encourage our younger members to take on decision-making roles, helping shape the future direction of our organization and developing their leadership skills within a supportive community.

Enhanced National and International Representation

Kerala has a wealth of talent, and it's time we showcase it on a broader stage. Increasing our presence at national and international forums is a priority. By supporting UAK members in scientific and organizational activities at these levels, we aim to create pathways for greater engagement in conferences, symposiums, and leadership roles within the wider urological community. This will not only elevate our members' profiles but also highlight the expertise that Kerala brings to the field of urology.

Promoting Research Output

Urology is an ever-evolving field, and research plays a pivotal role in driving this progress. We aim to encourage more research publications from Kerala, creating platforms for collaborative projects that showcase our contributions to urological science. This is an area where we can truly make a mark, and I urge each member to explore ways to contribute to the collective research output of UAK.

Building Leadership in Science, Practice, and Organisation

Together, we are committed to fostering a culture of excellence that spans clinical practice, research, and organizational involvement. This holistic approach will strengthen our association and help us collectively make an impact in the field of urology.

I am confident that by working together, we can realize these objectives and take the Urological Association of Kerala to new heights. Let us all commit to this journey of growth, leadership, and scientific excellence.

Warm regards,

Dr.Vinod K V MCh (Uro)
President,
Urological Association of Kerala

Secretary's Report
Annual Report 23-24



Dr Balagopal Nair M
Secretary

Greetings to one and all; at the outset thank you for this opportunity for doing some work for UAK

The current council took over at the abridged 37 th Annual Urology Association of Kerala conference along with the 34th Association of Southern Urologists conference organized by Trivandrum Urology Club under the able leadership of Prof Vasudevan Potti and Dr Renu Thomas.

It has been the endeavour of this council to promote research, teaching and work for the benefit of our members. To this end various initiatives have been taken

Starting with UAK PG teaching program for which we got a ZOOM digital connection for 100 participants. The program started under the guidance of Joint secretary Dr Manikandan M with faculty from both within and outside Kerala weekly twice on a Thursday. It saw active participation from students and enquiries from outside the state also. The Zoom portal was also used for UAK executive council meeting. Till now we had 3 physical and Zoom meetings.

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. The participation from UAK members was dismal probably due to prior commitments and lot of conferences taking place around the country. Since there were no papers and posters submitted for presentation, these sessions were cancelled. It was very distressing to find that there was 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 and there was no paper for the ASU best paper category from Kerala at the recently concluded Madurai SZUSICON 2024

In view of this background the council decided to have slight alteration in best paper these researchers for furthering their publications into a publication. We have also given adequate time for submission with extensions in submission deadline. We also plan to assess.

The UAK as part of promoting leadership among its young members a leadership seminar for the members was conducted on 25 August 2024 at Monsson Empress, Kochi. It was 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 (Prof Dr Raveendra Sabnis and Prof Dr Keshavmurthy Ramaiah along with members from our association who have been active took part under the guidance of our President elect Dr Vinod KV. There were about 40 participants from across the state. The revamped UAK website was also launched at this meeting. The take away saw formation of various UAK committees

UAK news letter

I would like to congratulate the editorial secretary in bringing out three high quality newsletter which is there for everyone to see. There has been active participation from members in contributing articles for the newsletter. It is our suggestion that members can share their experience in managing interesting cases thus developing paper writing habit and gradually progressing to journal publication. I would also like to congratulate for updating of membership details by bringing out the google form

Membership Cell

Promoting membership drives and other related activities in the Urological Associations

UAK, ASU, USI - Dr Joju Varghese Akkara

International Membership – Dr Jithu

UAK Research & Data Management Cell

Dr Shal Kakkattil

Dr Aravind Ganapath

Advisors- Dr Ginil P, Dr Kishore TA

Technical Advisor (RIRS Project) – Dr.Jithunath

Practice Guidelines & Consents Cell

Dr.Fredrick Paul

Dr Renu Thomas

Clinical Practice Cell

Dr Arun B

Dr Anoop K

Dr Rajanikant

Dr Joju Varghese Akkara

Uro Devices Cell

Dr Krishnamohan

Dr Vinod KV

UAK Website

One the first activity this council took over was revamping of the website. For this we constituted a website committee within the council. Quotation for various vendors including the existing one (3) were collected and a Zoom meeting with each vendor was done individually. This was further deliberated in detail in the council and decided to go ahead with Ms/- Webconcepts in view of their experience in handling ASU and LUA websites and others also. UAK entered into a contract for the revamping and management of website. Charges towards this entire exercise along with maintenance of the website and membership management will be Rs. 225,000 (excluding GST). Annual renewal thereafter will be typically in the range of Rs. 40,000 per year.

A lot of work has gone into the revamping of the website with active participation from the council here I would like to particularly mention about the efforts of 2 of our council members. First, I would like to laud the effort of our President elect Dr Vinod KV who drafted a lot of material for the website making it almost paperless along with having regular zoom and telephonic meeting with the vendors correcting various aspects of the website. The second is the effort put in by Dr Vishnu Raveendran. The end result of all this is for everyone to see. There have been some glitches in the initial phase with membership ID's but all these are being promptly sorted out by the vendors. They have been gracious enough to come to Kollam to ease out the website for all our members. This time we had abstract and review paper submission both on website as well as by email to UAK office since it was the first time. It was found that although tedious but is useful in becoming paperless the membership application, submission of papers and abstracts for UAKON and also bringing out the UAK newsletter.

With the intention of making the website more active for members and information for public it has been suggested that a separate corpus be earmarked for the same.

The website was launched at the leadership meeting by Prof Dr Sabnis

Member achievements

Dr Rajeev TP was elected President elect of USI
Dr Vinod KV was elected Treasurer of USI
Dr Ginil Kumar took over as the president of ASU

Future UAK conferences

UAK was the first body that conducted the mega 2020 USICON and showed how a cohesive society can also conduct such an event fairly. The council has been deliberating on the conduct of future UAK conferences to be minimalistic, conducted by UAK itself with more emphasis on content and reducing the registration fee etc. This was carried forward in the midterm AGM at AIMS Kochi. It was proposed that a local organizing committee selected by UAK to conduct the conference under UAK. For UAK 2025 tentatively Kannur with Dr Goutham Gopinath as the organizing secretary was suggested KTCON 2025 is being organized by UAK details of same will be shared by the organizing secretary Dr Vijay Radhakrishnan

UAK initiatives

With the growing menace of PAE by other specialist the UAK executive committee through its office communicated to USI central office about the growing number of specialists from other specialities doing prostatic artery embolization. The urologists are in no way involved in the decision-making process for same. Only when the patient has a complication does he land up with the urologists. PAE as we all know has its indications but the problem is the promotion by so called specialists (interventional cardiologist/ interventional radiologist) in social media and other platforms as a one stop solution for prostate disease without any proper evaluation or indication. We have many patients with prostate disease approaching urologists in the outpatient department seeking an opinion on PAE.

We requested the Urological society of India as our national body to intervene in this matter by having a wider discussion bring out guidelines and give directions in this matter so that at the end of the day the patient benefits rather than develops problems. If required the national medical council should be involved and a legal opinion also sought

Council had discussion on having UAK initiative for public awareness as suggested by member Dr Sanjeevan KV. Acute scrotum in children adolescents and young adults was the area of concern. Editorial secretary Dr Joju suggested about an initiative for public to be aware about urology speciality and the diseases that a urologist deals with. It is decided to bring a detailed proposal for the same.

Thank you

Balagopal Nair T
Secretary UAK

Editorial Secretary's Report



Dr Joju Varghese Akkara
Editorial Secretary

Dear UAK Members,

After the UAK Annual Conference we are bring out this Newsletter of November 2024, apart from usual reports I have incorporated a very good article on Leadership in the Medical Field written by Dr. Ravindra Sabnis, an article on Varicocele by Dr. Rama Prasad, a Case report by Dr. Anil Mani, Uro Quiz and Common Urological Procedures.

Our UAK website has been revamped, and I request all members to update their details through UAK Website. Humbly request all UAK Members to contribute to the Newsletter, either in the form of case report or an interesting article or anything related to Urology. All our Newsletters are available on website. Once again thanking you all for the support extended.

Thanking you

Dr Joju Varghese Akkara
Editorial Secretary UAK

Wishing all the UAK Members

Merry Christmas
&
Happy Newyear 2025

Office Bearers - UAK



Dr Vinod K V
President – UAK



Dr Sanjeevan
President Elect



Dr Dineshan K M
Past President



Dr Balagopal Nair M
Secretary



Dr Rajanikant V S
Treasurer



Dr Manikandran
Joint Secretary



Dr Joju Varghese Akkara
Editorial Secretary

Council Members



Dr Vishnu R



Dr Suchindra Prasad Unni T



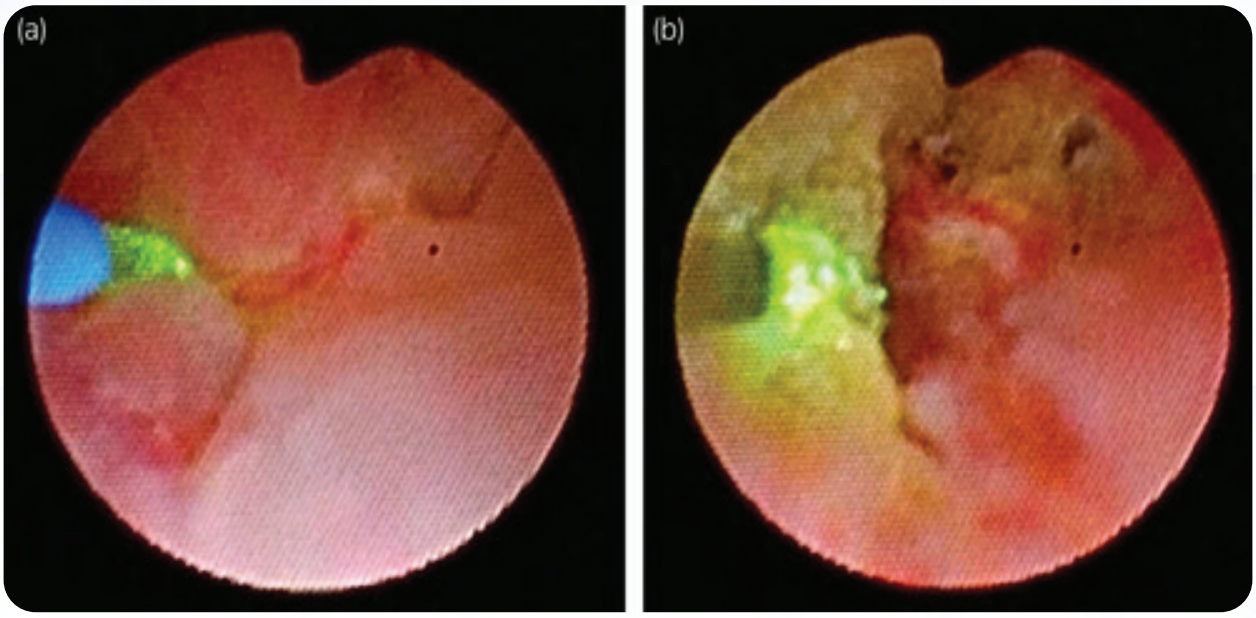
Dr Goutham



Dr Agish M

Uro Quiz Question

1.What are the common definitions of an impacted Ureteric Calculus?



Secretary's Message

The 38th annual Urological association of Kerala conference 2024 was successfully held at the picturesque Hotel Leela Ashtamudi, Kollam on 19-20 October 2024. The conference was a resounding success in all aspects with a record number of 175 registrations. To begin with the venue was excellent and the organizing committee under the leadership of Dr Bipin Das and Dr Agish M left no stone unturned for the delegates to have a pleasant and memorable experience. All the senior members of Kollam Urology Club played an important part. This was quite evident as mentioned By Dr Vinod KV when they welcomed the dignitaries on the dais during the inauguration and in handing the reins to the young guns.

Dr Rajeev TP our beloved Urological society of India President elect was aptly the chief guest. In his address he thanked all the members for UAK for their constant support. He also mentioned about his endeavour to bring Association of southern urology; President Dr Chengalvarayan graced the occasion and felicitated the organisers and delegates. He talked about ASU's initiative in developing a legal cell

Urological association of Kerala President Dr Dineshan KM addressed the august gathering and mentioned about the activities of UAK over past one year including the revamped website, post graduate teaching program and leadership meeting. He also mentioned about the dismal participation in UAK's midterm meeting.

It was an academic feast curated by the scientific committee with detailed discussion on select common core areas in general urology (Urolithiasis, Bladder outlet obstruction, reconstructive urology and infections).

The icing on the cake was the Prof Roy Chally Oration given by
Prof Dr Madhusudan Agrawal on Endoscopic combined intrarenal surgery a new perspective "Best of both worlds: RIRS or PCNL - End of the debate". There was active participation from the post graduates with approximately 50 presentations in all categories. The best paper category saw active participation from the floor.

Kollam hospitality was seen in the food and cultural event also. It was a gastronomic experience and the inaugural dinner had a splendid cultural performance by Cochin Tarang Beats.

Forthcoming programs of UAK include the Midterm meeting at Caritas Hospital in April, KTCON 2025 at Crown Plaza, Kochi on 10-11 May 2024. 39th Annual UAKON at Kannur on 11-12 October 2025

Balagopal Nair T
Secretary UAK

UAK Kollam – Photos

38th Annual Conference
19 & 20 October 2024








UAKON 2024
KOLLAM
UROLOGICAL ASSOCIATION OF KERALA
Hosted by : KOLLAM UROLOGY CLUB
2024 October 19th -20th
The Leela ASHTAMUDI (A Raviz Hotel)


UAKON 2024
KOLLAM
38th Annual
Conference of the
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38th Annual
Association of Kerala
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UAKON 2024
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UAKON 2024
KOLLAM
38th Annual

Article

Leadership in the Medical Field Write Up



Dr. Ravindra Sabnis
Chairman & Senior consultant,
Dep. of Urology, MPUH Nadiad

Leadership in the Medical Field: Key Insights and Importance

Leadership plays a critical role in the medical field, influencing every aspect of healthcare, from patient care to organizational management. Whether it's a junior resident or a senior consultant, everyone assumes leadership at some point in their career. However, as medical professionals progress, leadership becomes increasingly significant, requiring more than just technical expertise it demands vision, teamwork, ethical decision making, and adaptability.

Leadership in Medicine: Learning and Growth

Leadership is not innate; it can be learned. While some develop leadership qualities through trial and error, the medical field increasingly recognizes the value of acquiring leadership skills through formal training and scientific methods. By understanding what makes a successful leader, medical professionals can better navigate the complexities of their field.

Types of Leadership Roles in the Medical Field

Leadership roles in the medical field are diverse, spanning various levels of responsibility:

- Department Level: Resident, Assistant Professor, Professor, Head of Department (HOD)
- Medical College: Assistant Dean, Dean
- Private Hospitals: Consultant, Medical Superintendent, Director
- University Level: Senate Member, University Committee, Vice Chancellor
- Urology Associations: City, State, Zonal Leadership, National (USI), and International Associations (SIU, UAA, WCE)
- Other Medical Fields: Indian Medical Association (IMA), National Medical Commission (NMC), and various medical councils
- Specialized Fields: Leaders in organ transplantation (ZTCC, NOTTO, SOTTO), research, guideline committees, and government-appointed advisory roles
- Academic Organizations: Leadership in National Board of Examinations (NBEMS), university roles like Senate or Vice Chancellor

Importance of Leadership in Healthcare

Leadership in healthcare can cater to various aspects – focusing directly on patient care to a leading a team of doctors responsible to several other aspects of health care

•**Improved Patient Care**: Leadership is essential for setting clinical guidelines, ensuring standard care practices, and fostering a coordinated team approach to patient management. Regular meetings, morbidity and mortality reviews, and feedback discussions all contribute to better patient outcomes. Leader will ensure that best quality treatment is offered to the patient by him or his teammates under his supervision.

•**Efficient Resource Management**:Leaders allocate staff, prioritize duties, manage finances, and reduce resource wastage. Proper resource management helps optimize care delivery while ensuring long-term sustainability.

•**Boosting Morale and Ad apting to Change**: Leaders guide their teams through periods of uncertainty or undesired outcomes, such as unsuccessful surgeries. They also drive the adoption of new technologies and methods, creating a supportive environment where team members can embrace change.

•**Ethical Decision-Making**: Upholding high standards of ethics is fundamental in medical leadership. A leader's ethical decision-making fosters respect within the team and assures patients of the integrity of their care.

•**Crisis management**: In medical field, disaster can come any time. Such as earthquake with mass casualties, Riots, accident where in sudden efflux of critical pts arrive for treatment. Or it can be outbreak of some pandemic like covid19, influenza, swine flu...etc in such situation, leader has to grasp the situation, analyse & execute best possible option to tide over the Crisis successfully.

•**Preparing for next in line**: It is one of the important aspects of leader that, identification of a person next in line who can take over role of a leader & nurture him properly so that sudden vacuum is not created by your exit.

Leadership in Urology Associations

Urology associations provide a unique platform for leadership, starting from the grassroots level. Leadership here is earned through hard work and dedication, rather than through "parachute landings." Successful leaders in these associations work tirelessly for the organization's betterment, without hidden agendas. They think innovatively, make sound decisions, and are skilled at convincing others to follow their lead.

Leadership in Broader Medical Fields

Organizations like the IMA and NMC require leaders who excel in networking and fully understand the goals and operations of their positions. Leaders in these fields must ensure they do justice to their roles, focusing on the betterment of the profession and public health.

Specialized Leadership Roles

In fields such as transplantation, leaders often head programs like NOTTO and SOTTO, oversee research initiatives, serve on guideline committees, or act as advisers to the government. These roles involve policy-making and shaping the future of healthcare, such as advising on pandemic responses, vaccination policies or cancer awareness....etc.

Leadership in Academic Organizations

Medical academic leadership spans a range of roles, from NMC's branches on accreditation and ethics to leadership in NBEMS as conveners or even presidents. University leadership positions, such as Senate members or Vice Chancellors, are critical in shaping medical education and research.

Core Leadership Qualities in Medicine

Successful medical leaders embody key traits:

- Vision: Leaders must have a clear direction and the ability to turn that vision into reality.
- Guidance: A leader is someone who "knows the way, goes the way, and shows the way."
- Ethics: Maintaining high ethical standards is crucial in building a respected leadership presence.
- Adaptability: Leaders must embrace new technologies, methods, and approaches to ensure their team is always at the forefront of medical advancements.

Conclusion

Leadership in the medical field is both a responsibility and an opportunity. Whether in hospitals, academic institutions, or professional associations, effective leadership drives better patient outcomes, fosters team collaboration, and ensures the medical profession remains adaptable and ethically grounded. By developing the necessary skills and vision, medical professionals can rise to meet the challenges of leadership and contribute meaningfully to the future of healthcare.

Varicocele Clinical Significance.



Dr. Ramaprasad M K
Senior Consultant Urologist,
Aster Medicity Kochi.

Varicocele correction and its clinical significance.

Varicocele, as all of us are aware, is an ailment known from an early period of human history. It's an ailment of which the existence and relevance is shrouded in the veils of ambiguity. It is well known that clinically apparent varicocele should be treated in case of a man with infertility. Significance of ultrasound scan for diagnosis of varicocele is debated. But, in populations with darker complexion it is often challenging to diagnose varicocele with certainty especially if it is of low grade. In ultrasound examination, a venous diameter of more than 3mm or a reflux of more than 2 seconds duration is considered to favour a diagnosis of varicocele.

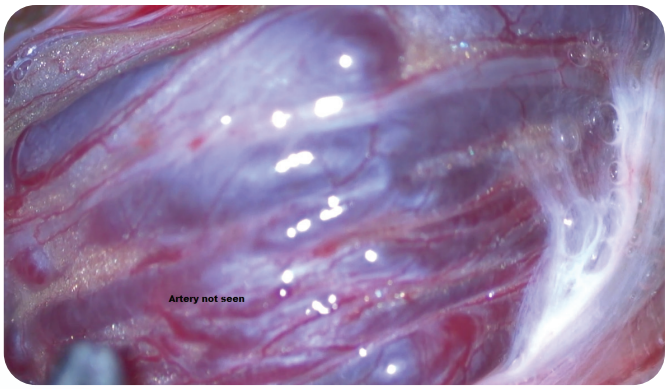
Anatomy of the spermatic cord related vasculature:

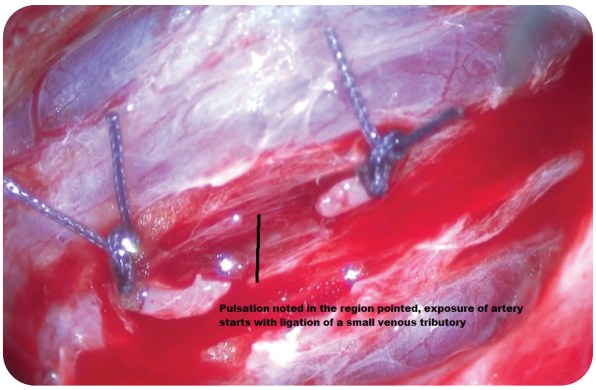
It is important to have a detailed understanding of the vascular anatomy of the spermatic cord for a successful corrective procedure. The veins draining the testicles include the internal spermatic veins, cremasteric veins and the vein of the ductus deferens. It is found that there are dilated external spermatic veins in nearly 70 percent of men with varicocele in addition to the dilated internal spermatic vein. These veins are present in the floor of the inguinal canal and are seen in an inguinal approach. These veins form a collateral path for the venous channels in relation to the spermatic cord. Gubernacular veins are found in around 50% of cases

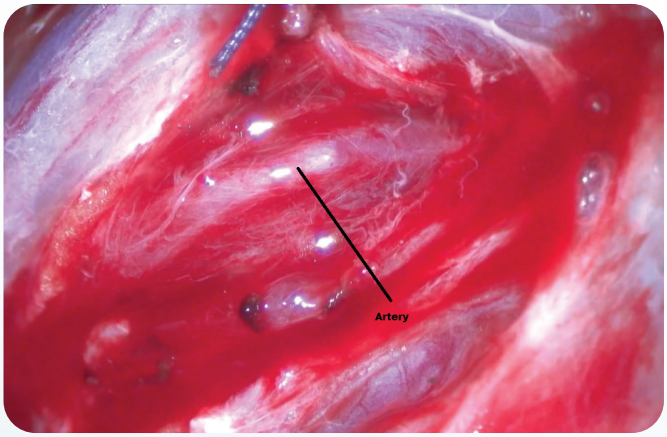
The spermatic artery has three branches: internal spermatic artery, external spermatic artery and the ductus deferens artery. The external spermatic artery originates from the inferior epigastric artery. It supplies the cremasteric muscle. At the superficial inguinal ring, the external spermatic artery anastomoses with the internal spermatic artery. The anastomotic network forms an arterial network to supply the tail of epididymis and lower part of the testis. The ductus deferens artery originates from the inferior vesical artery. It supplies the ductus deferens, epididymal tail, body, and lower part of the testis. A damaged testicular artery near the superficial inguinal ring leads to testicular atrophy. During varicocelectomy it is seen that Internal spermatic arteries are surrounded by a dense complex of adherent veins in 95% of cases T(this finding is true in only 30% of cases with the inguinal approach).

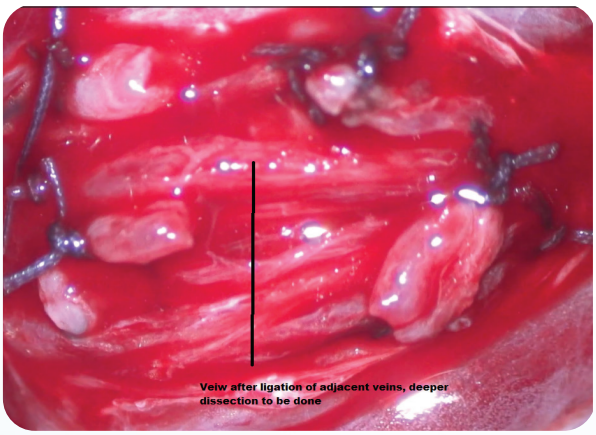
Anatomical considerations in Microsurgical subinguinal varicocele surgery:

1. The number and size of the internal spermatic vein network is highly varied during MSV. All the veins are to be identified under maximum magnification and divided.
2. The blood pressure has to be adequate while identifying the testicular artery. The artery may be attached to the undersurface of the large spermatic vein or may be engulfed by a network of delicate veins.
3. It may be impossible to separate all the veins to expose the artery and then ligate the vein in some of the cases. In such situations the veins have to be dissected and examined for pulsation and then ligated thus exposing the artery.
4. Identification of an artery in the spermatic cord does not mean absence of another artery in the subinguinal region. Hence, each structure should be examined for a pulse before ligation.
5. There may be vasal veins enlarged associated with varicocele. Those enlarged veins should be ligated after identifying the testicular artery.
6. The role of testicular delivery and disconnection of the gubernaculum is less clear and is not a part of standard procedure of MSV.
7. The external spermatic vein is not ligated in standard MSV. There is a trend towards inguinal approach with ligation of external spermatic veins to avoid recurrence.









While counselling the patient, the result we expect after treatment should be clearly stated.
In a man with infertility:

1. The total spermatozoa count is the parameter with maximum effect.
2. There are conflicting results regarding the effect of MSV on motility and vitality.
3. A man with azoospermia and bilateral varicocele can have spermatozoa detected after varicocele correction.
4. There is evidence for improved DNA fragmentation index after varicocele surgery. This may be important in the case of a couple undergoing ICSI.
5. There is evidence of improved pregnancy outcomes after varicocele surgery in infertile couples.
6. According to some studies, the resolution of pain after varicocele surgery is up to 90 percent even though this is found to be not true in clinical practice. The resolution of pain after surgery is not guaranteed after varicocele correction.
7. In adolescent patients' surgical correction of varicocele is warranted only if there is evidence for testicular growth retardation. EAU 2024 guideline recommends surgical correction of varicocele in adolescents with a persistent small testis (size difference of > 2 mL or 20%), which should be confirmed on two subsequent visits performed six months apart.
8. In men with hypogonadism, varicocele correction can lead to an improvement in hormonal milieu.

Conclusion:
Microsurgical approach is the standard approach for varicocele correction. An inguinal approach may reduce recurrence. Preservation of the testicularartery is of importance while doing varicocele correction. Mean blood pressure is an important factor which helps in the identification of arterial pulsation along with maximum magnification. Varicocele correction in a man with clinical varicocele leads to improved motility and pregnancy rates for the couple and is a part of infertility treatment.

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Case Report

Dr Anil Mani
MCh – SGPGI, Lucknow
Consultant Urologist,
Moulana Hospital,
Perinthalmanna



Title – Metastatic RCC in paracaval node without evidence of primary; further complicated by port site metastasis post excision

Introduction

Renal cell carcinoma is known to metastasize to virtually every other organ in the body. The most common sites for metastasis are the lung, bone, lymph nodes, brain, liver, adrenal glands and the contralateral kidney. Metastasis usually develops years after treatment of the primary. But 30% of the tumors can present with synchronous metastasis1. Metastasis without a primary mass is extremely rare and can pose a diagnostic and therapeutic challenge.

Case report

A 56-year-old female presented with an incidental finding of a 3.5cm paracaval mass (figure- 1) which was picked up in the follow up radiological workup for renal calculi. Her medical history was significant for CKD and Diabetes Mellitus with a baseline serum creatinine of 2.3 mg/dL. Her surgical history included RIRS for renal and upper ureteric calculi. A core biopsy was done from the mass and was reported as metastatic adenocarcinoma. In view of no evidence of a primary, an FDG PET CT scan was done. FDG PET showed uptake in the paracaval region mass (figure -2) only and no uptake elsewhere.

She underwent laparoscopic excision of the mass (figure- 3). Perioperative period was uneventful. Biopsy reported the mass as metastatic carcinoma with clear cell morphology. Immunohistochemistry was positive for CD10, Pax8 and AMACR and negative for CK7/CK20 and Napsin A suggestive of a possible renal origin. She was kept on follow up with plan for repeat imaging after 6 months.

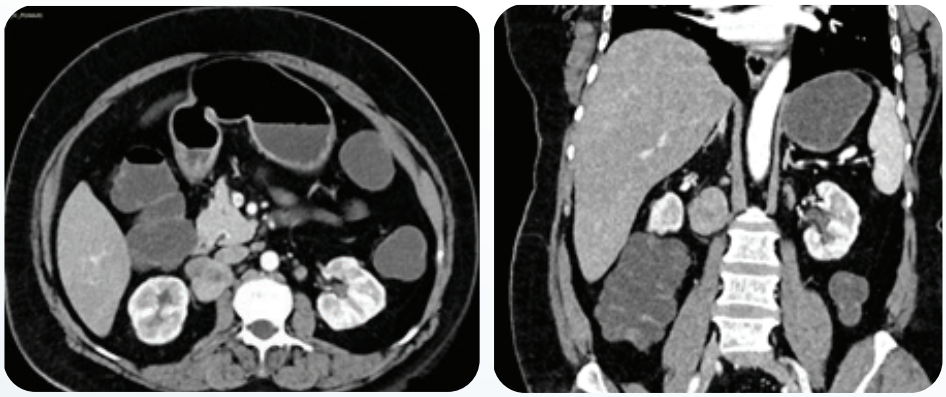


Fig 1: CECT abdomen showing a 3.5 x 3cm paracaval mass

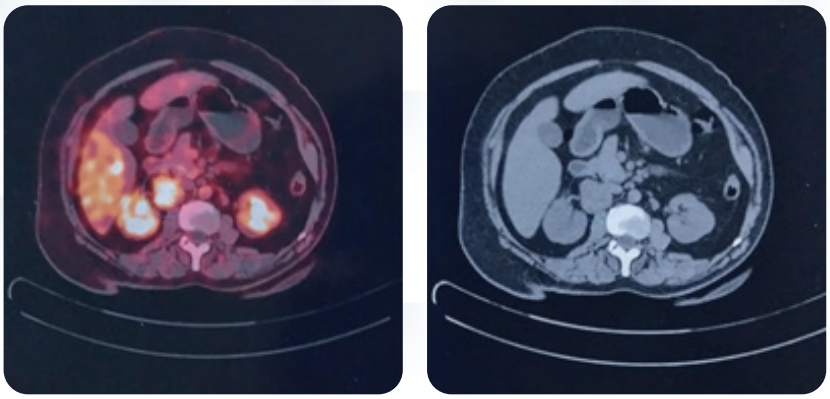


Fig 2: FDG PET-CT showing uptake in the parcaval mass

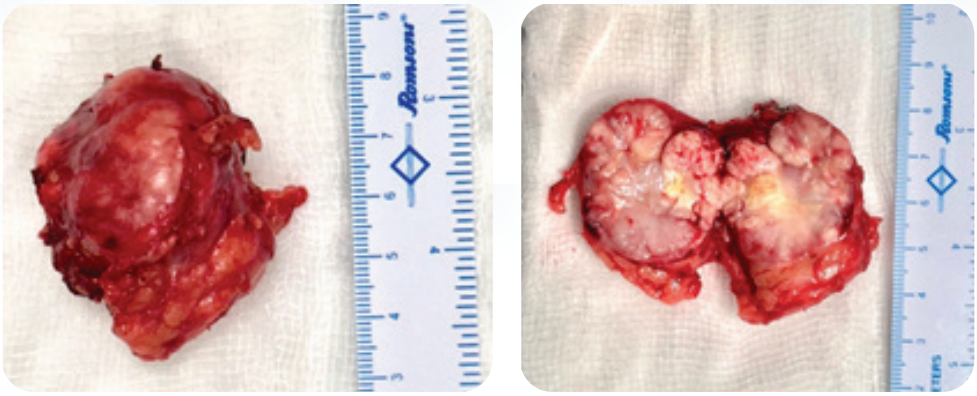


Fig 3: Excised parcaval mass with cut-section

In the postoperative follow-up after 6months, a repeat FDG PET scan was done. FDG PET-CT detected a port site metastasis (working port) with an SUV max of 7.4 (figure -4). It showed no significant uptake in the kidneys or paracaval region. She underwent excision of the nodule. Histopathological examination showed similar clear cell morphology. The patient is doing well at present and is under close follow up.

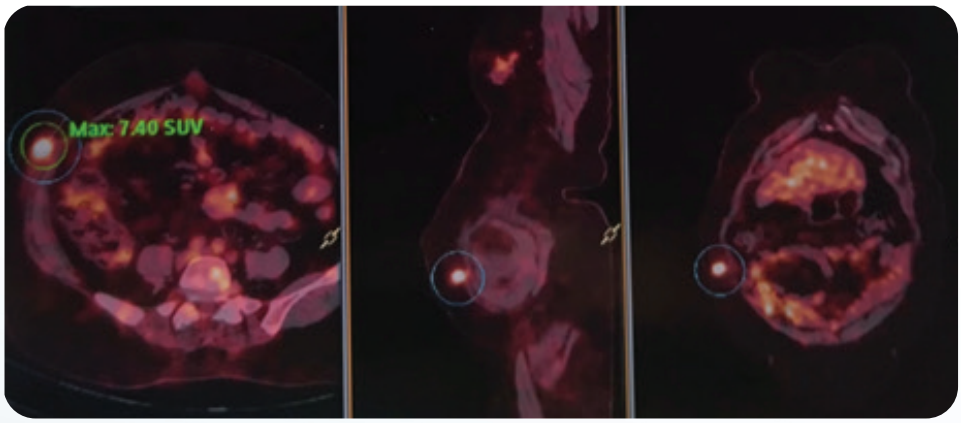


Fig 4: Follow-up FDG PET-CT showing uptake near port site

Discussion

Metastatic RCC without evidence of a primary mass is extremely rare and the literature reveals only a handful of such reports1,2. Incidental detection of metastasis is being increasingly common owing to the technological advances and easier access to imaging. Metastatic disease without a primary presents a challenging situation to the treating physician. Diagnosis is mostly dependent on immunohistochemistry staining to find out the probable site of origin.

The exact mechanism of such occurrences is unknown. The following are considered as the probable mechanisms of RCC metastasis without a renal mass2.

1.The volume of the primary mass is too low to be evident in the routine radiological imaging. However, in such cases, an FDG PET should pick up some activity which was not the case in our patient
2.EIRT (Ectopic immature renal tissue) – The other and more probable ex planation is the presence of Ectopic immature renal tissue with a ma lignant potential. The common sites of EIRT reported are lumbar/ sacral region and 11% occurred in the retroperitoneum3.

CK7 and CK20 are one of the most common markers used to assign the site of origin of metastasis with occult origin4. RCC are negative for both CK7 and CK20. PAX2 and PAX8 are expressed in normal kidneys as well other renal neoplasms. They are transcription factors essential for the development of kidney, Mullerian structures and other organs. They are highly reactive and have higher sensitivity than other renal tissue markers. Hence, they are given primary consideration during workup for metastatic RCC. All clear cell and papillary renal cell carcinomas are positive for CD10. However, the broad expression of it in other malignant neoplasms makes its use limited in differentiating metastatic RCCs. α- Methylacyl Coenzyme A Racemase (AMACR) is expressed in normal hepatocytes, proximal renal tubules and bronchus. It is positive in all papillary RCCs and rarely positive in other subtypes5. Napsin A is usually positive in lung adenocarcinomas and clear cell carcinomas of the gynecological tract and thus a negative test rule them out6.

Once the probable site of origin is identified, complete surgical excision along with close follow up is the treatment mandated in such conditions. Adjuvant radiotherapy and chemotherapy may be warranted according to specific case scenarios.

Port site metastasis (PSM), in its own is a rare occurrence in minimally invasive management of renal cell carcinoma. PSM in urological malignancy is more common in transitional cell carcinoma and only a few reports are available for the same in renal cell carcinoma. Many factors have been hypothesized for the mechanism such as 1) biological aggressiveness of the tumor, 2) local wound factors, 3) host immune response and 4) technical errors7. Chaturvedi et al in 2012 have hypothesized that PSM might be a result of hematogenic seeding and homing of these cells at the site of injury

in highly malignant tumors and not necessarily due to tumor violation8. Song et al in 2014 have reviewed 16 cases of PSM in renal cell carcinoma and suggested that PSM is not an isolated metastasis but instead a harbinger of future metastasis. 1yr survival rates were comparable to or worse than widely metastatic disease7.

This is the first report of PSM when a metastatic RCC mass is excised without excision of the primary. The site of PSM was away from the specimen retrieval incision which was again done within an entrapment bag. Song et al in 2013 have described similar metastasis at the camera port after RAPN for renal cell carcinoma and proposed aerosolization, escaping air causing a chimney effect and seeding of tumor cells into liquid suspension as the probable mechanisms9.

Conclusion

This case adds to the limited literature available on metastatic RCC without primary. Such condition commands prompt diagnosis with tissue immunohistochemistry to identify the site of origin and multi-disciplinary involvement in the management. According to the current literature, management includes excision and/or radiotherapy or chemotherapy. Port site metastasis after minimally invasive management is a rare occurrence. Technical factors are considered to have a role in PSM.
However, long term follow-up studies of such patients strongly suggest that factors such as biological aggressiveness of the tumor may play a bigger role.

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Common Urology Procedures

Semi Rigid Ureteroscopy
Basic Steps You should always follow

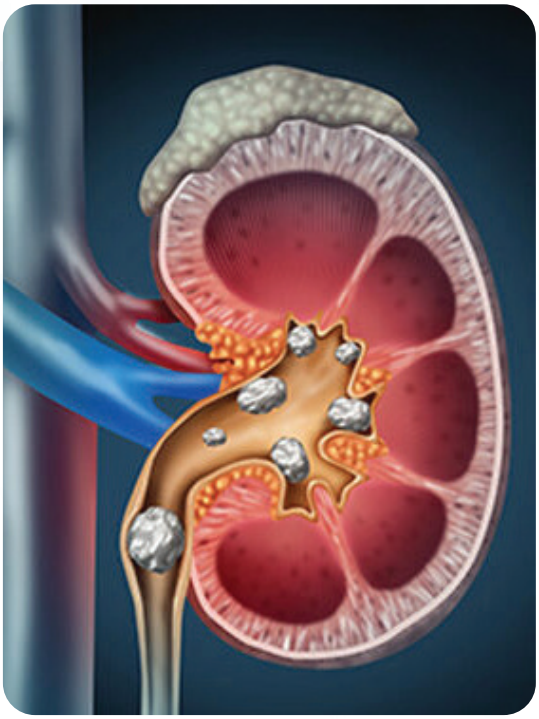


1. Preliminary Diagnostic Cystoscopy
2. Safety guide wire passed up through ureteric orifice
3. Retrograde Pyelogram
4. Withdrawal of Cystoscope without dislodging safety guide wire
5. Leave the bladder empty
6. Safety guide wire placed inside sheath and clamped
7. Ureteroscopic image white balanced and focused
8. Do not interfere with focus during the procedure
9. Check irrigation and remove air bubble before starting the procedure
10. If possibly pass the scope between the two guide wires
11. Always use gentle pressure on the scope when Ureter is tight rather than active force
12. Withdraw the scope intermittently to ascertain that lower ureter is not gripping
13. While withdrawing the scope visualizing ureteric walls moving away from you
14. When in doubt always use contrast and fluoroscopy to delineate anatomy of ureter and PCS

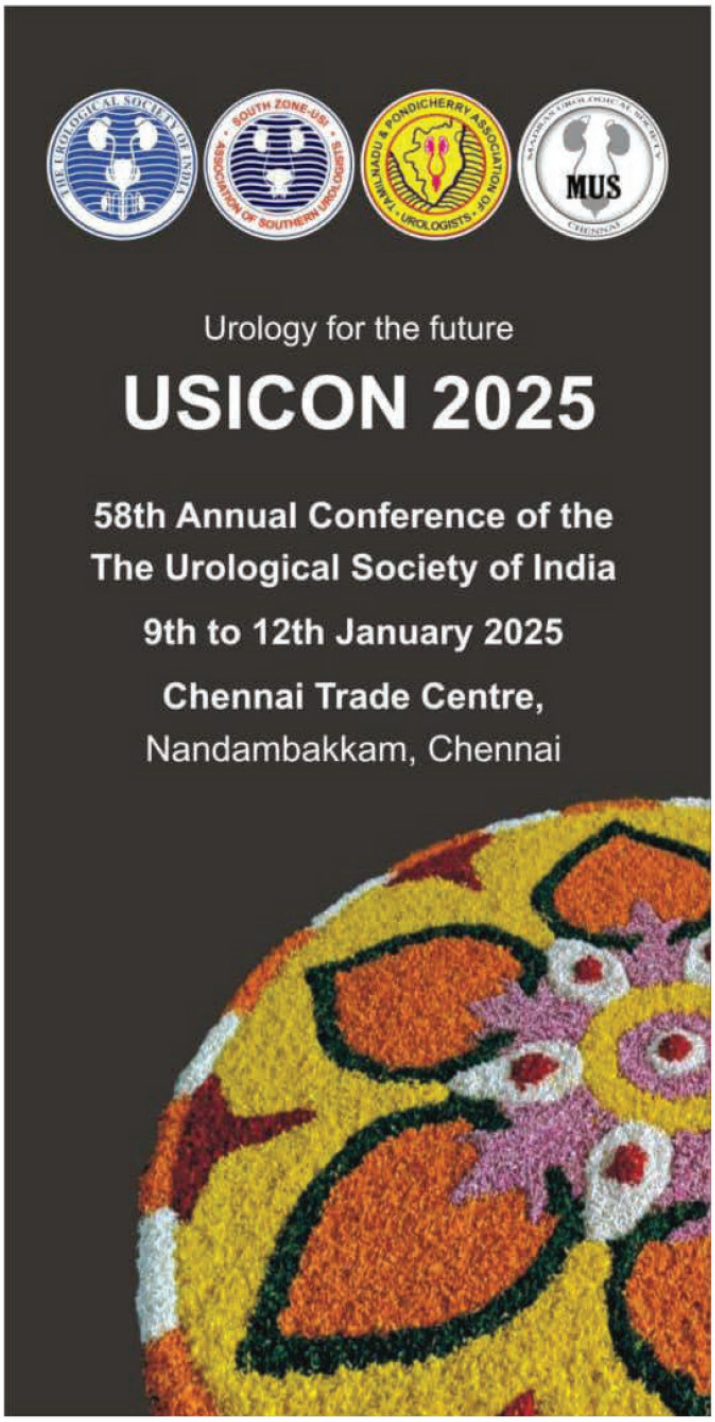
URO Quiz Answers

Ans. Impacted Stone is usually defined as an intra-operative finding, some of the common definitions are

1. Inability to pass the guide wire on initial attempt
2. Calculus causing Ureteric obstruction that remain in position for two months or greater
3. Failure to visualize contrast medium beyond the stone



Upcoming Events



UAK Mid-Term 6th April 2025, Caritas Hospital, Kottayam.

KTCON 2025, 10 & 11 May 2025 Crowne Plaza, Kochi

UAKON 2025 Kannur 11th and 12th October 2025

Obituaries



Dr. Sunil Jacob (61)

Passed away on October 7, 2024. A dedicated Urologist, he served at Ananthapuri Hospital and Jubilee Hospital in Thiruvananthapuram.
Dr. Sunil Jacob was an esteemed alumnus of Calicut Medical College. (Mch 1994- 1996)

After that he worked with Roy Chally sir then in Perinthalmanna, Kolenchery, KIMS Trivandrum

He is survived by his wife, Lini; son, Jacob (IIM Udaipur); daughter, Swetha (Capitaire, Kochi); son-in-law, Kuruvila Kapil (KPMG, Cochin); and grand daughter, Diya.

In Loving Memory of
Dr. N.K. Sanil Kumar
(1966 – 2024)



Obituary by (Dr. John Abraham)

It is with profound sorrow that we announce the passing of Dr. N.K. Sanil Kumar on 12th July 2024, at the age of 58. He left us suddenly due to a massive myocardial infarction, leaving behind a legacy of compassion, dedication, and excellence in medicine.

Born and raised in Pathanamthitta, Dr. Sanil Kumar was a bright student who began his academic journey at S.N. College, Kollam, before pursuing his MBBS and MS in General Surgery at Trivandrum Medical College.
He underwent DNB Urology training at Medical College, Kozhikode.

Dr. Sanil Kumar devoted his life to serving patients with empathy and skill. He worked at Pushpagiri Hospital , Lakeshore Hospital and later Lisie hospital, Ernakulam where he earned the respect of colleagues and patients alike. He also engaged in freelance practice at Ernakulam,

contributing to institutions like Karothukuzhi Hospital,Aluva.

Losing both parents to cancer deeply shaped Dr. Sanil Kumar's journey, inspiring him to become a staunch advocate for cancer care. He actively supported the Cochin Cancer Center, working alongside Justice Krishna Iyer to further its mission and bring hope to countless families.

Dr. Sanil Kumar is survived by his loving wife, Dr. Akhila, a Consultant Ophthalmologist; his son, Sanand Karunakaran, an accomplished architect; and his sibling, who resides in the United States. He was a devoted husband, father, brother, and friend whose warmth and wisdom touched all who knew him.

May his soul rest in eternal peace.