JANUARY 2012 - issue (i)

UAK NEWSLETTER

OFFICIAL NEWSLETTER OF THE UROLOGICAL ASSOCIATION OF KERALA

From The Editorial desk:

Dear Colleagues,

I wish you all a very peaceful, healthy, prosperous and a Happy New Year! It gives me immense pleasure to present to you, the first edition of the UAK newsletter for the year, 2012! After the silver Jubilee grand, celebratory UAK KOVALAM 2011, annual conference, this newsletter reaches you, just after another urological extravaganza, the USI annual conference2012, in Bangalore! It was with some trepidation that I offered to take up the post of editorial secretary of the Urology Association of Kerala, considering that the last edition was roughly, two years ago.I admit that wiping off the cobwebs, clearing up the dust, oiling and cranking up this communication machinery of the association, appeared a daunting task. However, thanks to the scholarly guidance and tireless effort of the editorial team, my task was made so much lighter!

The regional urology clubs of our state are remarkable for their regularity, attendance and enthusiasm for presentations with academic discussions and videos of high standard. Sharing those insights of unique clinical situations on the associations' state platform (and not merely confining it to the annual conference), on a regular basis, could be treasure trove of urosurgical experiences. The individual Club secretaries have been contacted for a state level link up, by regular contributions of interesting cases/ articles/events through this newsletter and our own active website: www.uakonline.com. We are happy to note the positive response. We have made a modest attempt at making this issue informative, relevant, concise and attractive. We also seek your response and contributions through articles and interesting case material.

New Year is the time to unfold new horizons and realize new dreams, to rediscover the strength of faith within you, to rejoice, in simple pleasures and gear up, for the new challenges. Wishing you a truly urologically fulfilling 2012.



Dr Sanel Varghese Chandapillai
Hon UAK Editorial Secretary.

Editorial Board

Dr. Suresh Bhat
Dr. K.V. Vinod
Dr. Georgie Mathew

President's Message

Dear teachers, professors and friends in urology,

At the onset, I wish to thank you all very much for reposing your confidence in my leadership capabilities and electing me as the president of the Urological Association of Kerala. I consider this elevation of my status as a symbol of your love and confidence. As has always been the thrust bearing area of the UAK, the major stress this year will be on academic activities and helping to keep the post graduates and their knowledge fine tuned and in line with the latest developments and research. I wish the inaugural issue of the UAK newsletter to be an effective communicator and commend the work of Sanel Varghese and Poulose Chally.



With warm regards and wishes for a Happy New Year,

Dr A.N Thomas,
President UAK

Secretary's Message

A very happy and prosperous new year to one and all,

It has been indeed a great pleasure and privilege to be elected as the secretary of the UAK. 25 yrs have passed since its inception and what glorious years those were. But we cannot rest on our laurels and we must try to achieve greater heights. I would like to think of UAK as a beautiful garden with various plants with flowers blooming.

For a professional body to grow, its needs encouragement and support of all its members. A more active participation by all the members is what we should strive for. There are many of us not involved in teaching but this does not mean that our work should not be presented and acclaimed by others and we would like to see more submission in the coming meetings. Dr. Sanel Varghese has taken upon himself, the task of reviving the UAK news letter and I am sure would welcome the contribution and encouragement of fellow urologists. Dr K.V Vinod is planning a video workshop in Trivandrum in April and I earnestly encourage all members to participate in it.



Let me end by saying that behind every successful urologist is another urologist from whom we learned something. So let us contribute to and learn from each other in all our gatherings

Dr Poulose Chaly,
Hon Secretary ,UAK

UAK Office Bearers

President	**: Dr AN Thomas**
Vice President	**: Dr Hamsa Thayyil**
Hon. Secretary	**: Dr Poulose Chally**
Treasurer	**: Dr Fredrick Paul**
Jt Secretary	**: Dr Vasudevan**
Editorial Secretary	**: Dr Sanel Varghese**
Executive Members	**: Dr. Ginil Kumar, Dr Shanmuga Das, Dr. Sathyendran Nambiar, Dr. Saju PR**








UAKKOVALAM2011 Report

The Silver Jubilee annual conference of the Urological Association of Kerala was conducted on the 29th and 30th of October 2011 at Hotel Samudra, Kovalam, Trivandrum.

It was jointly organized by the Department of Urology , Govt. Medical College, Trivandrum & Trivandrum Urology Club.

Around 180 delegates, most with families, registered and attended the grand conference, at the very scenic Kovalam beach Hotel Samudra.

Prior to the formal inaugural function , as is customary, two topics on allied subjects were presented by Radiology Professor Roy N, and Nephrology Professor Ramdas Pisharody, on the role of MRI in Urology and optimal immunosupression in Live Donor Renal Transplantation, respectively. Both the topics were very informative and with a lot of practical take home messages.

The Andrology session followed ,with Dr Col Ravindran Nair's presentation on use of color Doppler for evaluation of E.D; Current status of drugs in E.D management by Dr T R Murali. This session concluded with Dr K.V Vinod highlighting issues and concerns of varicocelectomy for male infertility.

The formal Inaugural function was an elaborate and well orchestered ceremony. The honorable minister for Health, Kerala State, Adv. Adoor Prakash, graced the occasion, formally inaugurating the silver Jubilee meet of the UAK, with the lighting of the traditional lamp. The dignitaries who addressed the gathering were Dr V Geetha, (Director of Medical Education), Dr Ramdas Pisharody (Principal , Medical college, Trivandrum), Dr David Joseph (Patron of the conference) Dr.George. P Abraham, (President of the UAK), Dr Syam K Ramesh (Organising Chairman) and Dr G. Venugopal (Organising &Hon Secretary of the UAK). A souvenir was released on the occasion by the DME.

The CPC session lived up to its reputation of the rollercoaster excitement as in a good crime thriller. Dr Dineshan K.M, the discussant treaded cautiously with each investigation report perhaps, more carefully than Sherlock Holmes. Prof. K Sasidharan ,in the chair steered the discussion with flair and skill as contributions from the floor gathered momentum. The discussion reached a crescendo as Dr Vinod K.V uncloaked the exoterica. ***It was an uncommon case of a T.C.C involving the renal pelvis and causing renal vein thrombosis and perirenal stranding.***

The UAK Annual Oration 2011 was delivered by Dr K.R Vikraman, Trivandrum. Chaired by the President and Secretary UAK, this plenary session was on Nephron sparing surgery in RCC. It was a well illustrated and didactic oration delivered with poise, verve and zest. A transpicuous exposition on a more complex subject of Transpubic approach for female urethral reconstruction by Prof. Sasidharan followed.

A panel discussion on the various nitty gritty of ***Renal Transplantation***, relevant to urologists was presented. The panelists were Dr Poulose Chaly, Dr Joseph Thomas,Dr V.N Moni,Dr Madhusunan, Dr Sreedharan Unni and Dr Sivarakrishnan. The topics covered were Donor evaluation and safety of the expanded criteria, legal issues of Donor selection, abnormal donor vessels, pretransplant nephrectomy, dos and don'ts of ureteric reimplantation and closing with, risks and outcomes in renal transplantation.

A sumptuous lunch followed.

The much keenly followed session in the afternoon was the ***video session***. A Kochi show , the variety of cases presented ranged from Laparoscopic Pyelolithotomy& pyeloplasty in a child, retroperitoneal adrenalectomy, lap diverticulectomy in a child , lap partial nephrectomy, presacral tumor excision, etc.

Considering its popularity, a separate brain storming session on the ***finer techniques of laparoscopy*** in urology was held with topics like single port access, pediatric laparoscopy, Retroperitoneoscopy, oncosafety margins in Lap. and deliberations on effective Laparoscopic training were held. The speakers for the session were Dr George P Abraham, Dr Vijayan. R, Dr Sanjay Bhat, Dr G Venugopal and Dr S Vasudevan

Another nugget of wisdom, another insight, tips and tricks were the focus of all attention as the session on ***"How I do it?"*** unraveled. Masters in their trade shared unique glimpses into their fine skills acquired through experience, as they sought to enlighten the delegates on access in difficult URS, RIRS/PCNL, Pelvic floor repairs, selection of Alpha blockers, Management of post TURP retensions and surgery for tuberculosis Bladder. Dr S.V Kandasami, Dr Appu Thomas, Dr Syam K Ramesh, DR Suresh Bhat, Dr Abdul Azeez, Dr Krishnamurthy and Dr George Joseph tackled the issues on the above mentioned topics.

The General body meeting was held after the last of the academic sessions for the day(minutes in separate section)

The night cultural programme included scintillating classical dance













performances followed by standup comedy and musical ganamela by a group of talented doctors of Trivandrum Medical College. The lavish spread was a gourmet's delight as one was spoilt for choice with a variety of local exotic marine cuisines. A memorable evening of rollicking fellowship, melodious live band, spontaneous laughter and gustatory indulgence, climaxed with spectacular fireworks!

Day two:On the 30th of October 2011 was the last day of the conference.

For the the ***Podium session*** , there were interesting papers on various reconstructive procedures like neobladder after radical Cystectomy, Episadias repair, retroperitoneoscopic Lap pyeloplasty,Placenta previa involving urinary Bladder and eye openers to stage migration of Ca Prostate in Kerala.

Topics of interest and importance to Post Graduate students were dealt in the morning ***P.G session.*** Varied topics like small renal masses, Ca Prostate screening, URS accessories,Lasers, Radiation Hazards in urology were covered with comments from senior faculty.

P.G URO QUIZ was conducted by Dr Manu P.K. The answers were discussed thereafter and this was keenly followed by all.

The ***Oncology session*** was a very interactive and informative session with topics like emerging tumor markers in Ca prostate(by Dr Ginil Kumar), ureteroscopic management of ureteric TCC (by Dr Sajeevan)and testicular sparing surgery(Dr Harikrishnan) generating a lot of interest and questions. ***The moderated poster session*** witnessed a number of rare entities and curious cases like a series of double malignancies in urology, reflex anuria, female urethral leiomyoma, ganglioneuroma of Adrenal gland etc.

With the ***valedictory function*** the ***new office bearers of the Urology Association of Kerala took over the reigns of the administrative function.***

List of Winners at UAKKOVALAM 2011

1. Best Paper (Teaching Institution)	:	**Dr. Vijay Radhakrishnan**, Calicut Medical College
2. Best Paper (Non Teaching Institution)	:	**Dr. R Vijayan** ,Specialist's Hospital , Kochi
3. Best video	:	**Dr R Vijayan**, Kochi
4. Best poster	:	**Dr Arun Ramdas Menon**, Calicut Medical college
5. UAK Quiz : 1st	:	**Dr Mohammed Aslam** Medical college, Kottayam
2nd	:	**Dr Vijay Radhakrishnan**,Calicut
6. Komaranchath Prize	:	**Dr H.Krishnamoorty**, Kochi

Highlights of the Annual GBM held on 29.10.11

- *The president Dr George P Abraham presided over the meeting and called the meeting to order.*
- *The president highlighted the need to improve academic program and scientific content.*
- *The secretary Dr Venugopal read the **minutes of the general body meeting held in Thrissur 2010**. This **was passed** by the general body.*
- *The secretary Dr Suresh Bhat **submitted the audited accounts of UAK for the financial year 2010.** He asked members to submit proposals to enhance the charitable / educational activities of the association. This was passed by the general body.*
- ***Election of the new office bearers** (listed on page 1)*
- *The house finally decided to accept "**Role of PDE5 inhibitors in Urology**". The Hon secretary informed the house that **Dr Rajeev kumar, Addl professor Urology AIIMS** has agreed to give the oration for the year 2012. The topic of oration would be **"surgical management of infertility"**.*
- *Dr Shanmughadas from calicut was selected as the **Quiz master** for the year 2012.*
- ***Venue of SZ-USICON 2014**- Dr H. Krishnamoorty **proposed Kochi** as the venue and was seconded by Dr George P Abraham. Same was accepted by the house.*
- ***Venue of UAK 2012-** Dr Sathyendran Nambiar **proposed Kannur** and was seconded by Dr A N Thomas. This was approved by the house.*
- *It was decided by the house that Dr Vinod k V,**Tiruvanathapuram**, would host the **mid term meeting of the UAK in March 2012.** He proposed to conduct a one day video workshop*
- *Decision to rename the annual oration as "**Professor Roy chally oration**" and that a sum of Rs 5lakh be been deposited for the same.*
- *The secretary highlighted the importance of involving the maximum members particularly senior faculty in the academic activities and workshops to be conducted under the banner of UAK. He also raised the point that preference should be given to members to exhibit their skills and talent*
- *Lap Endofusion was conducted under the banner of UAK and Cochin urology club.*
- *The **new office bearers** of the association **were installed**.*






Invited Paper

LAPAROSCOPIC ADRENAL SURGERY

Sudhir Sukumar, Santosh Jadhav, Balagopal Nair, **Sanjay H Bhat**, Ginil P Kumar, and Georgie Mathew

The laparoscopic approach for excision of the adrenal gland was first described by Gagner *et al*. in 1992.[1] Over the years, several series have established laparoscopic adrenalectomy (LA) as the gold standard for the removal of adrenal lesions of almost any pathology in adults.[2–4] Utilization of laparoscopy for adrenalectomy in the pediatric and adolescent age groups is much lower, due to the relative infrequency of adrenal masses in this patient population associated with a relatively higher incidence of malignancy;[5] other factors like small body size and inexperience with smaller laparoscopic instrumentation may also limit the enthusiasm among surgeons for this approach.[6]

This study reviews our experience with LA in children, at a single referral centre.

MATERIALS AND METHODS

This is a retrospective study of all laparoscopic adrenal surgeries performed on pediatric patients at our institute from January 2003 to May 2010. Patient medical records were reviewed for demographic data, preoperative evaluation and diagnosis, as also preoperative details, postoperative hospital stay, complications, histopathological features and follow-up data.

All patients underwent preoperative biochemical evaluation to rule out functional tumours. Radiological imaging with contrast-enhanced computed tomography (CT) or magnetic resonance imaging (MRI) scans was done in all patients to assess the size, side, local extent and distant metastasis. Additionally, metaiodobenzylguanidine scans were carried out during evaluation of functioning adrenal medullary lesions.

As in adults, the blood pressures of children with biochemical or clinical evidence of phaeochromocytoma were controlled prior to surgery with alpha blockade, using doxazocin and beta blockade when necessary.

SURGICAL TECHNIQUE

All cases were performed by the standard lateral transperitoneal approach, which has been extensively described. The patients were positioned in the 45° lateral decubitus position and a sub-umbilical 5 mm or 10 mm port was used for a 30° telescope. Two 3 mm or 5 mm working ports were used — one in the iliac region and the other subcotric port was ustal port in the midclavicular line [Figure 1]; an additional 3 mm epigassed for liver retraction in right-sided procedures. Carbon dioxide was used for insufflation maintaining pneumoperitoneum at a pressure of 8 – 10 mm Hg. When bilateral LA was performed in a single stage, the patients were re-positioned and re-draped after completion on one side. For the left-sided procedures, early control of the adrenal vein was attained at its origin from the renal vein. This was accomplished after colonic and splenopancreatic mobilisation, without direct handling of the adrenal gland itself. For right-sided procedures, the right lobe of the liver was mobilised and retracted upwards after dividing the right coronary ligament. The sub-hepatic inferior vena cava was exposed to approach the adrenal vein at the superomedial corner of the adrenal gland. After division of the adrenal veins, the gland was dissected free. The specimens were routinely placed in indigenously prepared plastic bags and retrieved through the umbilical port, extending it judiciously when necessary.



Figure 1
Port positions for left laparoscopic adrenalectomy in a child

RESULTS

Ten adrenalectomies were performed in seven children during the seven-year period of study. The four boys and three girls had a mean age of 9.6 years and a mean body-weight of 28 kgs. All the patients were symptomatic on presentation [Table 1] and none had antenatally detected masses or incidentalomas. Preoperative diagnosis were phaeochromocytoma (n = 4), Cushing's disease refractory to pituitary surgery (n = 2) and ganglioneuroma (n = 1). Three children underwent bilateral single-stage adrenalectomy, while four underwent unilateral adrenalectomy — three on the left side and one on the right side.

Table 1
Demographics, perioperative data and final histopathology of seven patients

Sex / Age (Years)	Body Weight (kgs)	Presentation	Side / Size (cm)	Operative time (min)	Postoperative Stay (days)	Pathology
M /16	39	Hypertension	L / 5	75	4	Normal Adrenal
F / 12	55	Cushing's syndrome	R / 5 L / 5	270	5	Cushing's disease [Adrenal Hyperplasia]
F / 14	34	Hypertension	R / 5	130	4	Pheochromocytoma
F / 1	8	WDHA	L / 3.7	120	3	Ganglioneuroma
M / 14	25	Hypertension	R / 7 L / 5	250	6	Pheochromocytoma
M / 10	32	Cushing's syndrome	R / 5 L / 5	270	5	Cushing's disease [Adrenal Hyperplasia]
M / 0.5	3	Hypertension	L / 2.3	120	10	Neuroblastoma

WDHA – Watery Diarrhoea-Hypokalaemia-Alkalosis Syndrome

On radiological imaging, the sizes of the adrenal masses ranged from 2 to 7 cm (mean 4.8 cm) in the longest dimension. The mean operative time was 111 minutes for unilateral and 263 minutes for bilateral cases. Estimated blood loss was negligible (< 50 ml) in all cases. The same surgical technique was followed in all patients and early adrenal vein ligation was successfully accomplished in all 10 procedures. Two patients with phaeochromocytoma developed intraoperative hemodynamic fluctuations in spite of adequate preoperative preparation with alpha blockade and intravenous hydration. There were no open conversions, but terminal hand assistance was employed in one child to dissect and retrieve a 7cm right phaeochromocytoma with retrocaval extension.

Postoperative hospital stay averaged 5.3 days. One infant developed postoperative septic arthritis of the hip joint that required prolonged hospital stay and parenteral antibiotics. Those with Cushing's disease were transferred to the endocrinology unit for further management. There was no mortality in this series of seven patients.

The final histopathology [Table 1] revealed a normal adrenal gland in a teenage boy with uncontrolled hypertension, which required three anti-hypertensive drugs. His urinary vanillylmandelic acid levels were elevated and the preoperative CT scan was initially interpreted as a left adrenal mass; in retrospect, it was probably just a very prominent splenic notch. The histology of the female infant who presented with features of the watery diarrhoea-hypokalaemia-alkalosis syndrome

IN CHILDREN: LESSONS FROM A SINGLE CENTRE EXPERIENCE

J Minim Access Surg. 2011 Apr-Jun; 7(2): 141–144.

confirmed ganglioneuroma. The male infant who was evaluated for hypertension was operated with a suspicion of phaeochromocytoma, but the final histopathology was suggestive of a localised neuroblastoma.

The follow-up duration ranges from 24 to 87 months (mean — 54.4 months). The child with stage I neuroblastoma is on follow-up and continues to be symptom-free at 24 months. The children who had bilateral adrenalectomy are on replacement therapy with hydrocortisone and fludrocortisone. All the children have had a resolution of the clinical and biochemical markers of adrenal gland hyperfunction. None of the children have shown clinical or radiological signs of local recurrence or distant metastases during the follow-up.

DISCUSSION

The adrenal gland is considered suitable for laparoscopic resection because of its small size and retroperitoneal location.[7] It has established advantages over the open procedure in adults; these advantages are now being extrapolated to the pediatric age group also. Indications for adrenal surgery differ in adults and children. Literature reveals neuroblastic tumours to be the most common adrenal lesions, requiring excision in the pediatric age group;[6,8] there was one neuroblastoma and one ganglioneuroma in our single centre experience. The safety and feasibility of LA for all stages of neuroblastomas in pediatric patients (including infants) has been previously documented.[6–9] In fact, LA has even been suggested as an option for residual tumours that have a favourable cytoreductive response to chemotherapy.[10,11]

Unlike in adults, suspected phaeochromocytomas in children and adolescents need to be thoroughly evaluated to rule out bilateral lesions, extra-adrenal lesions as well as syndromic associations like multiple endocrine neoplasia, von Recklinghausen disease, tuberous sclerosis, Sturge-Weber syndrome and von Hippel Lindau syndrome.[6,7] As in adults, children also require preoperative preparation, with appropriate alpha adrenergic blockers. Operative precautions like early control of adrenal veins and minimal handling of the gland are followed, as for adults. The intraoperative haemodynamic fluctuations that may occur in patients with phaeochromocytomas are thought to be less common in laparoscopy than in open surgery and can usually be controlled with temporary cessation of the procedure and appropriate medical measures.[12]

Two children with Cushing's disease and one with phaeochromocytomas underwent bilateral LA under the same anaesthesia. The boy with bilateral phaeochromocytomas, as part of the von Hippel Lindau Syndrome, had a small left adrenal mass that was first excised; the larger right adrenal mass had significant retrocaval extension that necessitated insertion of the surgeon's non-dominant hand for the final stages of dissection. No special hand-assist ports were used and excision was completed with laparoscopic instrumentation. As the same incision was then used for retrieval of the specimen, the cosmesis was also not altered. The terminal hand assist is a modification we had previously used successfully in adults to complete difficult laparoscopic procedures, without an open conversion.[13] It facilitated overcoming difficult mobilisation in the later stages of surgery, while avoiding a hand port early on in the dissection. In this child, it was useful in excising the relatively large mass from the comparatively smaller intraperitoneal space.

Bilateral LA in children is not frequently reported and can be performed under one anaesthesia[11,14] or as a staged procedure.[6] Ideally partial adrenal gland preservation should be attempted in children undergoing bilateral adrenalectomy;[15] this was accomplished in the boy with the von Hippel Lindau syndrome, where a portion of normal appearing tissue from the right adrenal gland was left behind after excising the large tumour. The use of intraoperative ultrasound through laparoscopic ports has been prescribed to accurately delineate the adenoma and preserve the normal cortex,[16] but this is presently not available at our centre. In the children with refractory Cushing's disease, the need for complete ablation precluded conservative surgery.

Although other series has successfully used the retroperitonescopic approach for pediatric LA,[17–19] we routinely prefer the transperitoneal approach in pediatric laparoscopy. Of late we have started employing the retroperitoneoscopic approach for adrenalectomy in selected adults and as our experience improves, we hope to attempt this in children as well.

CONCLUSION

LA can be considered to be equally safe and effective in pediatric patients as in adults and is applicable for most pathologies. However, patient selection for laparoscopy is crucial and is dependant on the child's body habitus, as well as the experience of the surgical and anaesthetic teams. A low threshold for open conversion in the early phase of the learning curve is recommended. Terminal hand assist may be beneficial in difficult cases.



Dr. Sanjay H Bhat
Kochi



UAK salutes
the "Father of Indian Urology" & a Great Teacher
Dr. Hattangadi Sashidhar Bhat (HSB)
on his First death anniversary
(21st Jan 1921—19 Nov 2010)

"I firmly believe and fully realize that, I can only cut but it is God who heals, as a Doctor we are only HIS instruments…" (HSB)

Lapendofusion 2011

Under the chairmanship of Dr George P Abraham, the department of urology Lakeshore Hospital, Kochi conducted an international live laparoscopic workshop LAPENDOFUSION 2011 on August 13 and 14. A panel of 35 international and national experts brought forth an impressive display of all basic and advanced laparoscopic, endourologic and robotic procedures. 34 surgeries were performed at Lakeshore Urology thetres and telecasted live at Oman Hall, Le Meridien Hotel, Kochi. The workshop was attended by 400 delegates from all over India and abroad. The workshop was conducted under the aegis of Kochi Uroclub and Urology association of Kerala.





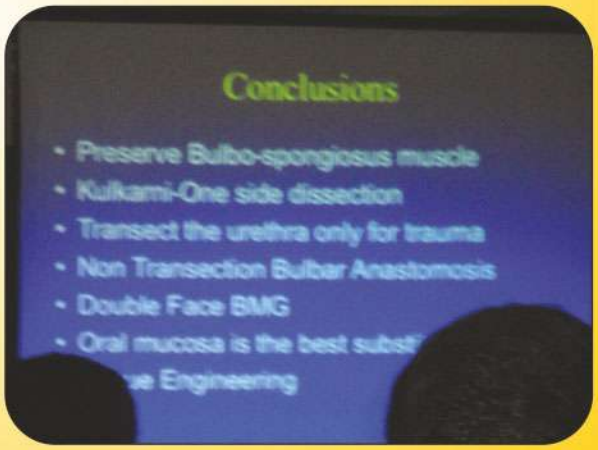
Regional News

Dr. Basil Alias Memorial Oration - Kochi 2011



Dr. Sanjay Kulkarni, from Pune, an eminent urologist and an authority on Urethral reconstruction, delivered the Dr. Basil Alias Memorial Oration on December 29, 2011 at the IMA Hall Cochin, organized by the Kochi Urology club.





" what is new in urethral reconstruction?"

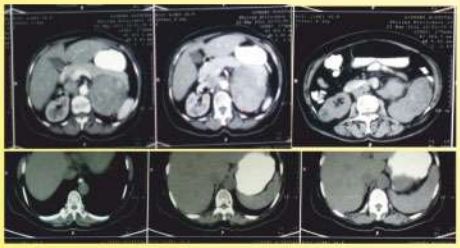
INTERESTING CASES

The Drama of Multiple Malignancies : Dr. H. Krishnamurthy,. Kochi.

61 yr old lady presents with tiredness and loss of weight of 6 months duration . Thin built, not a hypertensive or diabetic;Had a thyroid swelling of 5 yrs duration. General examination normal; Vital signs normal Abdominal examination: Mass in the left hypochondrium, moving with respiration

Firm-Hard thyroid nodule on the right lobe about 2 cm. Abdomen Ultrasound: Left renal exophytic mass lesion ? RCC & Large paraaortic mass (metastatic). Ultra sound of Thyroid: features suggestive of Thyroiditis; bilateral cervical adenopathy.

CT : 3 x 2.1 cm necrotic mass arising from the lateral cortex of lower pole of R kidney. Approx. 7.8 x 4.7cm lobulated exophytic mass lateral cortex upper and mid pole of L kidney. A 10 x 7.9 cm well marginated mass in relation to lateral limb of left adrenal gland. No IVC / renal vein / retroperitoneal lymphnodes involved. CT suggest ***bilateral renal Cell Carcinoma with left adrenal secondary deposit.***



Tests for functioning adrenal tumours. 24 hr urinary VMA normal. Serum corticosteroids normal. Serum electrolytes normal. FNAC: s/o Hashimotos Thyroiditis with evidence of Follicular Hyperplasia

Surgery done

Total thyroidectomy by the Surgeon. Left adrenalectomy. Left radical nephrectomy.

Patient had massive bleeding with hypotension, Patient on ventilator for 4 days Recovered. Discharged on the 8th post operative day

FINAL DIAGNOSIS: Thyroidectomy specimen- Papillary. Carcinoma of Thyroid in both the lobes & Hashimoto's Thyroiditis; Nephrectomy Specimen; Renal cell Carcinoma, grade1-2; Adrenalectomy specimen: possibility of Adrenal cortical tumor & pheochromocytoma (IHA suggested)

On late post operative follow up : Patient presented with severe cough and fever after two weeks of surgery; Polymorphonuclear leucocytosis. Chest X-ray showed left lobar pneumonia with pleural effusion(pleural tap negative for malignancy). Patient had to be put on ventilator again; Loaded with antibiotics and supportive measures; Recovered in 10 days time. Came for follow up after 4 months.

Radionucleotide whole body scan: negative for skeletal mets. Impression:- CT scan of the abdomen reveals. Hepatomegaly with two focal enhancing lesions segment 4a and 8 - suggest hepatic metastasis. Approx. 3 x 2.3 cm oval enhancing mass posterior lateral cortex of the lower inter polar region of right kidney - suggest Renal Cell Carcinoma. Left Kidney absent / no recurrence / no lymph nodes. CT scan suggest Renal Cell Carcinoma right kidney with hepatic mets.



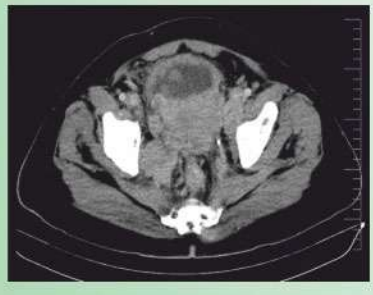


Masquerading Until Mayhem ! :- By Dr Dineshan K.m, Kozhikode

41 year old male with LUTS of four months duration.

Presented to us with history of Transurethral Incision of Prostate in August 2011 done elsewhere.(Findings: Inflamed prostatic urethra, TUIP done at 5 and 7 o'clock. PSA at the time was 2.3.)

LUTS persisted.He had developed acute retention of urine and had been catheterized at an outside hospital. No history of abdominal pain. No history of hematuria. No history of fever.Known diabetic on OHA. No other known comorbid conditions.





Pulse : 80/mt BP: 120/80;No pallor, no jaundice and no cyanosis. On Examination: Abdomen –NAD

System examination : NAD ;EG – NAD, DRE – Indurated hard prostate. No tenderness

Investigations:- Blood and urine routine WNL (few WBC in Urine)

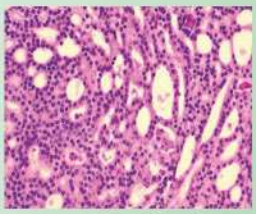
Ultrasound Abdomen: Multiple hyperechoic lesions in the liver - ? Metastasis.; Bilateral hydroureteronephrosis ; Heterogenous mass lesion 7 x 5 cm adjacent to external iliac vessels on right side - ? lymphnodal mass.

CT Abdomen: Malignant neoplasm of prostate gland with invasion of UB, Bilateral seminal vesicle and ureters with proximal moderate hydroureteronephrosis and pelvic and intra abdominal lymph nodal metastasis and hepatic metastasis.

Discussion: Patient presented with above mentioned complaints. Initially in view of normal PSA levels and Ultrasound abdomen findings he was managed as chronic prostatitis.

As he did not improve – Trucut biopsy prostate was done – which showed poorly differentiated adenocarcinoma – (Immuno Histochemistry Awaited). USG abdomen and subsequently CT abdomen was repeated which showed multiple nodal and hepatic metastasis.

He was counseled regarding his condition and he requested transfer to Regional Cancer Centre, Trivandrum .



Trucut Biopsy Prostate:
Poorly differentiated adenocarcinoma.
(IHC – Awaited)

Soliciting interesting Cases with Pictures for next UAK News Letter from all members

email: uaknewsletter@gmail.com website: www.uakonline.com

PG CORNER

QUIZ WHIZ !

(I) New therapies in Castration-Resistant prostate cancer:

(a) Cabazitazel is a new agent that has been used in treating post docitaxel metastatic CRPC. Combination therapy in the form of Docitaxel plus bevacizumab, docitaxel plus aflibercept (VEGF Inhibitor), docitaxel plus lenalidomide (angiogenic inhibitor) has also been found to be beneficial.

(b) Abiraterone a more potent, less toxic and selective CYP17 inhibitor has been approved for secondary hormonal manipulation.

(c) Sipuleucel-T is a vaccine that acts by activating the host antigen specific T cells.

(II) Optical Coherence Tomography (OCT) is an imaging technique that provides real time , high resolution , atraumatic, cross section imaging of tissues. It application in urology includes bladder cancer detection and staging and neurovascular bundle mapping. Elastography is an ultrasound based imaging technique using remote palpation or quasistatic compression for imaging tissue elasticity. Pathologic changes is biologic tissue correlate with change in the tissue mechanical properties . Elastography strives to assess these mechanical changes to detect areas within an organ such as prostate , which may harbour areas of cancer.

(III) Einstein vision-may be a cost effective alternative to the ROBOT in laparoscopic surgery. It incorporates a high definition 3D camera mounted in a remotely controlled arm. When used in combination with articulating surgical instruments, the precision and dexterity of robotic surgery can be duplicated with simplicity.

(IV) Radium-223, will it change practice in metastatic prostate cancer? (ALSYMPCA Trial) Radium, localizes to bone, similar to calcium .It is injected in to the circulation, localizes to bone metastasis and destroys the cells by alpha emission, with very little effect on the bone marrow. It improves disease free survival and reduces skeletal events. The drug is yet to receive FDA approval. (compiled by Dr Georgie Mathew, Kochi)

Conference Planner for 2012

1. UROVISION 2012 : Mid-term UAK Video workshop on Endourology at hotel Taj Vivanta ,Trivandrum: April 22, 2012 ; Ph:09995019951
2. HoLEP training at RG Stone centre, New Delhi, 17-18March,2012
3. PERCON 2012: 5th International workshop on basics & advanced techniques of PCNL: 14-15 April 2012, New Delhi;www.percon2012.com
4. Endourology2012: live operative workshop BJ Medical college, Pune; 27&28 April 2012
5. International Prostate Cancer Symposium at Rajiv Gandhi Cancer Institute , New Delhi 6,7 ,8 April 2012; 011-47022027
6. SZ-USICON2012 :July 13-15, 2012 at Hyderabad,AP
7. 11th Asian congress of Urology at Pattaya, Thailand, 22-26th August 2012
8. EUA 2012: Paris 24-28TH FEB 2012
9. AUA 2012 Atlanta, 19-23 MAY 2012
10. UAK Annual conference at Kannur, Kerala, October 27&28 of 2012
11. WORLD congress of Endourology, Istanbul, Turkey, Sept 4 – 8TH 2012 ;www.wce2012.org
12. SIU 2012 Fukoaka, Japan, September 30-October 4 2012; www.siucongress.org

UAK Members are requested to update their postal addresses

Address For Correspondence : Dr. Sanel Varghese
Editorial Secretary, UAK, 'Kairos', ACN-6, Opp. Holy Family School, Angamaly - 683 572, Kerala, India.
email: uaknewsletter@gmail.com web: www.uakonline.com