

plane abdominal X-ray. Treatment outcomes, including disintegration rate, stone-free rate, and retreatment rate, for both groups were also compared.

**Results:** Pre-SWL, the patient characteristics, treatment parameters, and stone-related parameter were similar for both groups. There were higher stone-free and disintegration rates in the electrohydraulic group for most stones, but the retreatment rate was higher in the electromagnetic group. There was no significant difference for stones at the middle and lower ureter and stones in the ureter bigger than 1 cm. The complication rates for pain, skin, or subcapsular hematoma were not significantly different between groups.

**Conclusion:** The electrohydraulic lithotripter (Medispec E3000) group has significantly higher disintegration and stone-free rates, but has similar complication rates compared to the electromagnetic lithotripter (Medispec EM1000) group. There is no significant difference between the two groups for middle or lower ureteral stones and ureteral stones bigger than 1 cm. The electromagnetic lithotripter has the advantage of being useful for SWL even without anesthesia.

#### NDP017:

#### RENAL STONES OUTLET OBSTRUCTED BY PARARENAL PELVIC CYST MANAGEMENT

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We often incidentally identified some renal cysts at OPD. The principles of non-obstructive simple renal cysts management is watchful waiting. However, some renal cysts need to be managed, such as malignancy tendency, renal pelvic-ureteral junction obstruction by those cysts. The management of renal cysts included aspiration combined with injection of sclerosing materials, and laparoscopic unroofing.

We presented a 60-year-old male who has multiple low calyceal stones with focal hydrocalyx. The renal pelvic-ureteral junction was extrinsic compressed by one large parapelvic renal cyst. First, non-enhanced abdominal CT scan was arranged and thus we clearly know the relative locations of cyst and pelvic-ureteral junction. Laparoscopic unroofing of renal cyst was performed. After surgery, we arranged intravenous pyelogram for confirming the pelvic-ureteral junction patency. Watchful waiting for spontaneous passage of multiple small renal stones was planned. Unfortunately, stone streets formations in low third and upper third ureter were found later. Ureteroscopic lithotripsy and double-J catheter were performed smoothly. Extraperitoneal shock wave for residual renal stones was performed, too. Last, we removed the double-J catheter. The clearance of renal stone was excellent.

#### LUTS

#### NDP018:

#### CLINICAL FINDINGS AND TREATMENT OF KETAMINE CYSTITIS: 8 YEARS EXPERIENCE OF CHIMEI MEDICAL CENTER

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**Purpose:** To evaluate the clinical presentations of Ketamine cystitis and efficacy of related treatment.

**Materials and Methods:** We retrospectively analyzed the clinical presentations among the 20 ketamine abusers who visited our out-patient department of Chi Mei Medical Center from January 2007 to December 2014. The clinical symptoms, laboratory results, cystoscopy findings & managements were all analyzed.

**Results:** All the patient included aged between 20–40 years. Most of them had moderate to severe lower urinary tract symptoms such as frequency, urgency, dysuria, urge incontinence & bladder pain. The severity of lower urinary tract symptoms parallel to the duration of Ketamine abuse. Various degree of interstitial cystitis under the documentation of cystoscopic examination. Nearly almost the patients were treated with hydrodilatation & intravesical hyaluronic acid instillation. However, the symptoms were significant improved in those abstinence from Ketamine.

**Conclusion:** Longer the duration of Ketamine abuse, the lower urinary tract symptoms became more prominent. Surgical intervention act as an adjuvant to symptoms relief, total cessation from Ketamine is more effective.

#### Laparoscopy

#### NDP019:

#### CASE REPORT: A GIANT PSEUDOANEURYSM AFTER ROBOTIC-ASSISTED LAPAROSCOPIC PARTIAL NEPHRECTOMY

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Partial nephrectomy (PN) is the standard treatment option for patients with small renal mass, such as clinical T1a to T1b renal tumors. Compared with radical nephrectomy, PN is a more complicated procedure with involvement of both vascular and collecting systems, and complications can occur. The incidence of renal artery pseudoaneurysm (RAP) after PN is between 0.4% and 2%. Minimally invasive procedures, such as laparoscopic or robotic-assisted approaches have a higher incidence of RAP when compared with open PN.

Here we present a 63-year-old male with incidentally finding of a right renal tumor, clinical stage of T1bN0M0. He underwent a robot-assisted laparoscopic partial nephrectomy (RAPN). The patient tolerated the procedure well and was discharged uneventfully. The pathology report showed a papillary renal cell carcinoma, pT1bNxMx, Fuhrman grade II, with a negative surgical margin. However, the patient presented to ER with intermittent gross hematuria aggravated since one month after the operation. Contrast enhanced computerized tomography (CT) scan demonstrated a large pseudoaneurysm of 5 × 4.4 × 3.9 cm in size over the posterior part of the right kidney at the incision site. Transfemoral renal angiography performed by a radiologist demonstrated a huge pseudoaneurysm from the posterior branches of the right renal artery. Selective embolization was performed with coils, glue and gel-foam cubes. The patient tolerated the procedure well and was discharged uneventfully.

#### NDP020:

#### IATROGENIC ECTOPIC URETER: COMPLICATION OF ROBOTIC-ASSISTED LAPAROSCOPIC RADICAL PROSTATECTOMY

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**Case description:** A 53 year-old male with the medical history of hepatitis B carrier. As family history of prostate cancer of his father, he presented to our urologic outpatient department for survey. Due to elevation of PSA level, prostate biopsy was done which revealed adenocarcinoma. Clinical staging was cT3aN0M0. However, he underwent robotic-assisted laparoscopic radical prostatectomy at other hospital. Final pathology revealed prostate adenocarcinoma, pT2cN0M0. After operation, he suffered from abdominal and urethral pain for about 1 month with a CWV and a Foley catheter retained. Therefore, he returned to our OPD for further survey.

Physical examination revealed lower abdominal tenderness. Meanwhile massive clear yellowish drainage from CWV noted daily (around 1500 to 2000 ml/day) and its creatinine level was 13.68mg/dL. There was no evidence of intraabdominal infection by ascites analysis. Under suspicious of anastomotic site leakage, he was admitted for a series of examination and treatment. Firstly, exchanged of urethral Foley was done, follow by cystoscopic examination which inflammatory change of trigone noted but right ureteral orifice could not found. Then, cystography illustrated no contrast medium leakage. After review post-OP CT scan of the hospital