urine retention for 3 months, anemia, and body weight loss 9 kgs. Except HIV infection, he had no other systemic disease. Due to detectable HIV viral load, the operation was delayed before visiting us. CT scan was done two months ago, revealing a 5 cm, round, heterogenous enhancement tumor, without lymphadenopathy. In our institute, transurethral resection of the bladder tumor (TURBT) was soon arranged after confirming his HIV viral load was undetectable. A large, broad-based, non-papillary tumor grew from bladder posterior wall was confirmed during the operation. However, the tumor size was much larger then 5 cm, which showed on the CT scan 2 months ago, and the total resected specimen was finally estimated to be 680 gm. After the operation, patient’s recovery was smooth, and he was discharged on post-operative day 7. Final pathology report revealed inflammatory myofibroblastic tumor. There’s no muscle invasion. Due to large broad-based tumor, and prolonged operation time with possible incomplete resection during 1st TURBT, 2nd-look TURBT was arranged one month later, and residual 35gm tumor was resected. The pathology report was the same.

Conclusion: IMT is a rare tumor, and had been variously named before, such as inflammatory pseudotumor, plasma cell granuloma, atypical myofibroblastic tumor, and atypical fibroxoid tumor. The pathogenesis of IMT remains obscure, with possible etiologies including autoimmune disease and infectious organisms. Controversy still exists that whether IMT is a truly neoplastic process, since its clinical course is generally indolent after surgical resection. Report showed local recurrence rate about 10%. No distant metastasis had been reported currently. Image findings are nonspecific and histologic confirmation is essential. The diagnosis should be differentiated from sarcomatoid carcinoma and leiomyosarcoma.

IMT had been reported in lung, liver, spleen, testis, larynx, small bowel, CNS, lymph nodes, soft tissue of HIV/AIDS patients. To our best knowledge, this is the first case report of bladder IMT in an HIV patient. Some author suggested that IMT may be related to immune reconstitution inflammatory syndrome (IRIS) in HIV-infected patients receiving HAART, which is an augmentation of inflammation that can occur during immune reconstitution in an immunocompromised host. However, due to rarity of the cases, whether the incidence of IMT is higher in HIV patients is unclear. In conclusion, IMT is a tumor with borderline malignancy. Complete surgical resection is important to avoid possible local recurrence. For bladder IMT, TURBT is adequate according to literature. Close follow-up is required.

**NDP07:**

**HUGE LEFT CLEAR CELL RENAL CELL CARCINOMA PRESENT AS RIGHT HUMERAL PATHOLOGICAL FRACTURE WITH PREDOMINANT SARCOMATOID CHANGE: A CASE AND LITERATURE REVIEW**

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A 83 year old male presented to ER with progressive right arm pain for 1 month. Further image survey revealed osteolytic lesion of right humerus suspecting pathologic fracture. Whole body CT scan showed a tumor 15.7 cm x 12.6 cm with central necrosis at lower pole at left kidney suspecting renal cell carcinoma. Later surgery of ORIF revealed pathology of bone as metastatic renal sarcomatoid carcinoma. After surgery of open left radical nephrectomy, pathology report showed left clear cell renal cell carcinoma with no regional lymph node involvement, and sarcomatoid feature < 5%, pStage IV pT3aN0M1. The composition of sarcomatoid feature was described as a final common dedifferentiation pathway, caused by extensive chromosomal rearrangement, which does not represent a distinct subtype entity, but rather used to predict a worse prognosis than those without sarcomatoid differentiation. In addition, recent studies showed that a cutoff of greater or equal than 25% of sarcomatoid component represent significant predictor for worse prognosis. As a result, the treatment strategy designed for our patient was based on 2014 NCCN Guideline for Stage IV clear cell renal tumor; and Pazopanib was chosen over Sunitinib for better quality of life, with mainly less side effects of fatigue, hand-foot syndrome and mucosal inflammation.

**NDP08:**

**RENSAL SURGERY EXPERIENCE IN CHANG BING SHOW CHWAN MEMORIAL HOSPITAL ALMOST ONE YEAR**

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**Purpose:** renal surgery experience in Chang Bing Show Chwan Memorial Hospital from 2014 Oct. to 2015 Oct.

**Materials and Methods:** the renal surgery including laparoscopic partial nephrectomy, laparoscopic radical nephrectomy, open radical nephrectomy, open partial nephrectomy, laparoscopic nephroureterectomy, total 10 cases from Oct,2014 to Oct. 2015.

**Results:** male and female ratio is 6:4, renal cell carcinoma (6 cases), urothelial carcinoma (1 case), angiomylipoma (1 case), atrophy kidney (1 case), renal cyst (1 case), average hospital stay are 6.5days, no surgical complication.

**Conclusions:** There are various indications for this procedure, such as renal cell carcinoma, a non-functioning kidney, urothelial carcinoma. Partial nephrectomy can preserve much normal kidney, minimal invasive surgery can provide patient rapid recovery.

**NDP09:**

**SPERMATOCYTIC SEMINOMA: A CASE REPORT WITH LITERATURE REVIEW**

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Spermatocytic seminoma is an uncommon subtype of testicular germ cell tumor and comprised 1.1% of all seminoma and the age standardized incidence rate was 0.4 per million. Age at diagnosis ranged from 19 to 92 years with a mean of 53.5 years. Spermatocytic seminoma is a testicular neoplasm which presents as a slow growing mass with or without pain. It arises more commonly in the right testis, and serum tumor markers are always negative. Metastasis is extremely rare, so surveillance alone is sufficient postoperative management. A 54-year-old patient visited our urology clinic due to a palpable right testicular mass with mild soreness for 3 days. Scrotal echo showed a 1.6 cm hypervascular mass at the upper pole of right testis. Magnetic resonance imaging revealed right testicular tumor with suspicious involvement of tunica albuginea. Serum alpha fetoprotein and beta HCG levels were normal. Preoperative abdominal CT scan demonstrated no inguinal, pelvic or paraaortic lymphadenopathy. He was admitted for right radical orchectomy and pathology confirmed spermatocytic seminoma (pt1). He recovered uneventfully and was discharged home 2 days after operation. We report the rare case and review the literature of spermatocytic seminoma.

**NDP10:**

**DIFFUSE LARGE B CELL LYMPHOMA IN URINARY BLADDER**

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We reported the case that a 58-year-old woman presented with dysuria and urinary frequency off and on for 2 weeks. She was a cleaner of gas station for 8 years and had history of hypertension and old cerebrovascular accident without medication before. Besides, she had no habit of smoking. She came to our emergency room for treatment. Initially, pyuria(White blood count:>100 high power field[HPF], red blood cell: 2-5 HPF, Sp.gr:1.007, nitrite: negative, leukocyte ersterase: +/+ ) were found. In addition, the