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NDP15:
PITUITARY GLAND ADENOMA WITH HYPERPROLACTINEMIA AND MALE ERECTILE DYSFUNCTION – A CASE REPORT

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Purpose: Prolactinoma is the most common type of pituitary adenoma and can cause hyperprolactinemia which is the most common cause of male sexual dysfunction. However endocrinopathy is the rarest of causes of male sexual dysfunction. To check routine serum prolactin level in the initial evaluation of erectile dysfunction has been questioned. Though check prolactin level only in case of low testosterone level is generally accepted. The first choice of treatment in hyperprolactinemia induced Impotence is bromocriptine. It can reduce the level of serum prolactin level together with improvement of sexual libido and potency
Materials and Methods: We report a case who suffered from erectile dysfunction for half one year. Laboratory data revealed severe hyperprolactinemia. Pituitary gland adenoma was found on magnetic resonance imaging. Neurosurgeon arrange transsphenoidal endoscopic pituitary tumor excision for this patient, and post operation follow up showed reduced serum prolactin level to near normal range. However, erectile dysfunction was still noticed. After combination of bromocriptine and testosterone administration, he claim great improvement of erectile function
Conclusions: In case of hyperprolactinemia with persist hypogonadism, combination treatment should be considered

NDP16:
NEPHEROSCOPE-ASSISTED DRAINAGE OF A MASSIVE RECURRENT RETROPERITONEAL ABSCESS

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Purpose: Retroperitoneal abscess is a kind of complicated disease, it can caused by renal stone, necrotizing fasciitis, appendicitis or even duodenal ulcer. Adequate drainage and coverage of appropriate antibiotics is necessary to treat retroperitoneal abscess. We demonstrate a special technique that use nephroscope as our instrument to drain a recurrent massive retroperitoneal abscess.
Materials and Methods: A 57 years old female, who had the history of right retroperitoneal abscess, s/p subcostal incision and drainage of abscess, complained about right flank pain for one week accompanied with mild fever. Lab data showed leukocytosis, KUB revealed lots air accumulation of right abdomen. Echo showed massive fluid accumulation over right para-renal space, about 19 cm* 10 cm in size. Under the impression of recurrent retroperitoneal abscess, we prescribed echo-guide nephroscope-assisted drainage of retroperitoneal abscess. After operation, there was just only one 2 cm wound. And drainage tube was inserted thru the wound to retroperitoneal space. After operation, her condition was quite stable, no spiking fever or septic shock was noted. And she was discharged after two weeks antibiotics treatment.
Results: The gold standard treatment of retroperitoneal abscess is adequate drainage. CT-guide or echo-guide drainage with pig-tail insertion may be the first choice. However, in some big abscess, pig-tail drainage is not enough and operation may be needed. The traditional way of retroperitoneal abscess drainage is subcostal retroperitoneal approach. And some people have demonstrated laparoscope-assisted drainage of retroperitoneal abscess. However there are some disadvantage such as wound pain and the concern of elevated retroperitoneal pressure associated sepsis. We described a special technique to create a small wound and under nephroscope guide, you can suction, irrigation, remove necrotic tissues or even insert adequate drainage tube.
Conclusion: Nephroscope-assisted drainage of retroperitoneal abscess is an ideal way to treat retroperitoneal abscess.

NDP17:
A CASE OF TOTAL RIGHT UPPER URETER OCCLUSION DUE TO CHRONIC PEFORATION PEPTIC ULCER WITH DUODENO-URETERAL FISTULA FORMATION

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A 50 year-old man with a diagnosis of large duodenal ulcer with fistula formation, seal-off perforation and retroperitoneal abscess with involved to right upper ureter. Right flank pain and abdominal pain was noted for about 1 year. Labrotory data revealed anemia Upper GI panendoscopy revealed a large ulcer with central necrosis debris at posterior wall of the bulb of duodenum. UGI and small bowel series revealed duodenal leakage to right retroperitoneal space and right PUJ and upper ureter were involved. Right upper ureter total occlusion and right hydronephrosis was noted after kidney sonography, right ureterorenoscopy and right retrograde pyelography. Right PCND was done for urine diversion. Tc-99m DTPA renography revealed GFR: left 80% and right 20%. In addition, PTCD for retropeitoneal abscess drainage was performed. After urine diversion, retreoperitoneal abscess drainage and PPI treatment for two months, duodenal fistula to upper ureter was still noted.
He was close follow up at GS and Urological OPD, Right flank pain was improved but duodeno-ureter fistula was still noted. Recently, right antegrade pyelography revealed right UPJ extravsation. Right nephrectomy and duodenal fistula excision was advise.

NDP18:
CASE REPORT: NON-OPERATIVE MANAGEMENT FOR GRADE V KIDNEY INJURY

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This is a 18 years old male with the history of traumatic head injury status post craniectomy twice. He was suffered from traffic accident which result in grade V shattered kidney with peripheral hematoma without CT evidence of contrast extravasation. Then conservative treatment given with Cefazolin and Foley indwelled. After PRBC 2U transfusion, his hemoglobin dropped gradually but static at the level of 11 g/dL.
Abdominal CT follow up on post-traumatic day 8 disclosed urinary leakage at right collecting system. After that, gross hematuria with intense right flank pain noted, so abdominal CT done again which suspicious of active bleeding. Therefore angiography arranged but there was no evidence of active bleeding. As right urinoma formation with leukocytosis, pigtail inserted for drainage. Meanwhile right JJ stent indwelled retrogradely too. The patient was discharged smoothly without any complications.

NDP19:
EMPHYSEMATOUS CYSTITIS – TWO CASES REPORT

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Urinary tract infection is the most common condition in urology clinical practice. Severe infection or even sepsis is mostly occurred in upper urinary tract. Emphysematous pyelonephritis is occasional noted and is life-threatening but emphysematous cystitis is rarely seen.
We presented one 92 y/o female and one 65 y/o female who visited our emergency room at March and November of 2014 respectively. Their chief complaints included fever, general weakness, cough, shortness of breath and were not specific. There was no lower urinary tract symptom except low abdominal discomfort were complained in both cases. Complete blood count showed leukocytosis with left shift in both of them. Urinalysis both showed hematuria and pyuria. High blood sugar level were noted in these