**NDP061:**
**BILATERAL ADRENAL TUMOR RELATED TO MULTIPLE ENDOCRINE NEOPLASIA TYPE 2**

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**Purpose**: Bilateral adrenal tumors are very rare in clinical practice. To differential diagnosis of bilateral adrenal tumor is also challenging.
**Materials and Methods**: A 29 year old man suffered from hypertension for over 2 years but with poor response to medical control. Incidental findings of thyroid nodule and bilateral adrenal tumor during health check up. Hyperparathyroidism was also reported after examination. Patient then received bilateral laparoscopic adrenalectomy.
**Results**: Multiple Endocrine Neoplasia type IIa (MEN IIa) an autosomal dominant syndrome characterized by pheochromocytoma, medullary thyroid carcinoma and hyperparathyroidism. Pheochromocytoma occurs in approximately 50% of patients with MEN IIa.
**Conclusion**: Hereditary pheochromocytoma should be kept in mild for patient with bilateral adrenal tumor. The association with MENII is also known. Further check up for thyroid, parathyroid function of patient and family should be considered.

**NDP062:**
**THE MANAGEMENT OF THE COMPLICATION OF POST NEOBLADDER RECONSTRUCTION– CASE REPORT**

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We reported 3 patients receiving laparoscopic radical cystectomy with orthotopic ileal neobladder reconstruction(M pouch).
**Case 1**: 56 y/o male had ureter-pouch disruption due to ureter stent dislocation, and he received open surgical revision and reanastomosis. However, colon perforation followed after second operation
**Case 2**: 51 y/o female had uretero-pouch anastomotic stricture four months later, and percutaneous nephrostomy with zebraguide wire antegrade insertion into neobladder was performed first then followed endoscopic ureter internal dilatation and catheter indwelling.
**Case 3**: 47 y/o male also had uretero-pouch anastomotic stricture, but endoscopic dilatation failed. He finally received laparoscopic ureter adhesion-lysis and ureteroneocystostomy under mini-open wound.

## *Oncology*

**NDP063:**
**THE FEASIBILITY OF LAPAROSCOPY RADICAL CYSTECTOMY FOR THE ELDER PATIENT ( >70 Y/O) WITH A 10 YEAR HISTORY OF ADVANCE UROTHELIUM CARCINOMA POST OPEN NEPHROURETERECTOMY AND ADJUVANT CHEMOTHERAPY**

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This 75 y/o male patient had past history of hypertension. Besides, he ever had right ureter transitional cell carcinoma (T3N2M1) status post right nephrouretrectomy and chemotherapy on 2004/07. After that he was regular follow up at our OPD. However, the recurrent bladder cancer s/p TUR-BT on 2008/6, 2010/5 and 2014/11. He also received the BCG instillation from 2010/05 to 2010/06 and Mitomycin transcather irrigation (6 times) from 2014/12 to 2015/01. Under the regular follow up cystoscopy and one papillary mass over right diverticulum was found on 2015/02. The MRU for tumor workup was arranged and bladder tumor (T2N0M0) was compatible. Then he received the radical cystoprostatectomy, left ureter-cutaneostomy and left iliac LN dissection by laparoscopy (transperitoneal approach) on 2015/3. There are two points for this case, including the treatment response is good for advanced stage TCC (the survival over 10 years) and laparoscopy is still feasible for patient ever received open nephroureterectomy 10 years later.

**NDP064:**
**SYNCHRONOUS IPSILATERAL RENAL CELL CARCINOMA AND UROTHELIAL CARCINOMA OF KIDNEY IN A PATIENT WITH PROSTATE ADENOCARCINOMA: A CASE REPORT AND REVIEW OF LITERATURE**

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**Introduction**: Single occurrence of renal cell carcinoma (RCC) or urothelial carcinoma (UC) of the upper urinary tract is frequent urological malignancy. However, synchronous and simultaneous occurrence is rare, particularly in a patient with prostate adenocarcinoma. Herein, we report a case of synchronous ipsilateral RCC and UC of kidney in a patient with prostate adenocarcinoma.
**Case Report**: A 76 year-old male with old pulmonary tuberculosis suffered from left flank pain for several months. MRI reveals a mass lesion about 6.4 * 5.4 cm in lower pole of left kidney, in favor of RCC. cT1bN0M0. Then he received robot-assisted laparoscopic radical nephrectomy. The intra-operative finding includes left side renal tumor over lower pole and posterior aspect with engorged tumor supplying vessels. The pathology reported as clear cell RCC with free margin (pT3aN0) and infiltrating UC (pT1) over renal pelvis. With elevated PSA (27.92 ng/mL), he also received transrectal ultrasound and biopsy. All the apex, middle, and base of left lobe are adenocarcinoma with Gleason's score 5+4 = 9. MRI reveals a heterogeneous low signal intensity lesion on the peripheral zone of left lobe of prostate on T2WI, and suspected tumor invasion into left seminal vesicle. There was no bone metastasis (T3bN0M0). He currently received combined radiotherapy and androgen deprivation therapy.

**NDP065:**
**NON-MUSCLE INVASIVE BLADDER CANCER WITH PROSTATIC STROMA INVASION: A CASE REPORT AND REVIEW OF LITERATURE**

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**Introduction**: The face of bladder cancer is heterogeneous, with about 70% presented with superficial tumors, which tend to recur but are generally not life threatening, and 30% presented as muscle-invasive disease that associated with high mortality rate due to distant metastases.
There were little information about infiltrating urothelial carcinoma metastatic to prostate without bladder wall invasion. Herein, we report a case of non-muscle invasive bladder cancer (NMIBC) with prostate invasion.
**Case Report**: A 73 y/o male with aggravated left flank pain was admitted to our institution for study, the abdominal CT revealed suspicious neogrowth in the urinary bladder. He refused to receive cystoscopy examination and then discharged. However, he returned 18 months later with persistent gross painless hematuria and urinary retention for one month. The IVP showed indentation of the bladder base and prostatic enlargement. Then he received TURP and TUR-BT. The tissue pathology reported that there were infiltrating urothelial carcinoma in urinary bladder with no muscle invasion and infiltrating urothelial carcinoma in prostatic stroma by invasion (pT4N0M0). However, there were negative for malignancy in urinary bladder base and margin. After surgery, he received radiotherapy and chemotherapy.

## *Urolithiasis*

**NDP066:**
**PELVIC ORGAN PROLAPSE RELATED GIANT URINARY BLADDER STONE – CASE REPORT**

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**Purpose**: Pelvic organ prolapse will cause many associated discomfort. In some situation, uterine inversion will accompanied with total urinary