NDP26:
LAPAROSCOPIC RADICAL NEPHROURETERECTOMY FOR UROTHELIAL CARCINOMA IN A HORSESHOE KIDNEY: A CASE REPORT AND LITERATURE REVIEW

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A 75-year-old male suffered from gross hematuria for months and was diagnosed with urothelial carcinoma in the left moiety of a horseshoe kidney. Laparoscopic left side radical nephroureterectomy with open bladder cuff excision through a Gibson incision. The patient was discharged on post-operative day five uneventfully. Preoperative computed tomography is quite valuable for the evaluation of the anatomical variations in horseshoe kidneys. In conclusion, laparoscopic approach is effective for managing malignancy in horseshoe kidneys.

NDP27:
SINGLE MASSIVE URETER POLYP CAUSING URETER INTUSSUSCEPTION: A CASE REPORT AND LITERATURE REVIEW

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Purpose: Ureteral intussusception is a rare complication caused by intra-ureteral lesions (i.e. ureteral calculi or ureteral mass). Here, we present a case of ureteral intussusception cause by single massive ureteral polyp.
Materials and Methods: This 44 years old man first presented at our ER symptoms of renal colicky pain and painless gross hematuria. After initial survey, IVP showed middle ureteral stricture without distal ureter enhancement. Due to symptoms of painless gross hematuria, cystoscopy and ureteroscopy was ordered. Intra-operative images showed huge polyp at lower 1/3 ureter and uretero-vesical junction. Biopsy was obtained and obstruction was relieved with electrocautery. Due to size of the polyp, malignancy was first suspected and CT scan was ordered and intussusception of middle ureter was noted. Biopsy later revealed to be fibroepithelial polyp of ureter.
Conclusion: Intussusception of ureter is a rare complication of intra-ureteral lesion with the typical presentation of flank colicky pain, hematuria and hydroureter. Most of the prior reported cases of ureteral intussusceptions were benign in origin, but the first case of intussusceptions caused by ureteral TCC was reported on 1987. Ever since, half of the reported cases of intussusceptions are related to intra-ureteral malignancy. Therefore, we also keep malignancy in our minds in cases with images of intussusceptions and the typical symptoms until proven otherwise with biopsy.

NDP28:
POTENTIALLY FATAL ARTERY ANEURYSMS PRESENTING WITH LOWER URINARY TRACT SYMPTOMS

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Purpose: We report a case of multiple potentially fatal artery aneurysms presenting with lower urinary tract symptoms.
Materials and Methods: A 71-year-old male had past history of hypertension without medication and smoking for 50 years. He suffered from urinary frequency and nocturia for 3 months. Because of persistent lower urinary tract symptoms, he went to our outpatient department for help. He appeared well and did not felt abdominal discomfort. There was no tenderness or palpable mass on his abdomen on examination. A digital examination revealed an enlarged prostate with two fingers in breadth and normal consistency. The rest of his physical exam was unremarkable. The urinalysis was unremarkable and PSA was normal. Bladder sonography disclosed two large hypoechoic masses above the bladder and prostate volume was 30 g. The following computed tomography showed 2 large sausage-like artery aneurysms of right common iliac and internal iliac arteries. The largest size of the aneurysms was 6.1 cm. It was likely that the patient's urinary symptoms were caused by local compression of bladder. Then he was transferred to the cardiovascular section and endovascular repair for the aneurysms was scheduled.
Conclusions: Lower urinary tract symptoms are common presentation in patient with benign prostatic hyperplasia. However, the other rare causes of lower urinary tract symptoms are difficult to detect by simple urinary test and digital rectal examination, even by transrectal ultrasound. Iliac artery aneurysms account for an estimated 2% of intra-abdominal aneurysmal disease. It had been reported that up to 40% present acutely with rupture. With a rupture rate of 38% and associated high mortality, early detection and intervention is essential. Bladder sonography is one of the important tool to find the potentially fatal lesions as this patient. Aneurysm should be always kept in mind when we treat the patients with lower urinary tract symptoms, especially that only with irritative symptoms.

NDP29:
SPONTANEOUS URETERAL RUPTURE: A CASE REPORT

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Purpose: Ureteral rupture usually results from traumatic, iatrogenic, or tumor-induced tear and leads to urinary extravasation. Spontaneous rupture is rare. Patients may presented with sudden onset abdominal or flank pain. Image studies often showed perirenal fluid accumulation.
Materials and Methods: We reported a healthy female patient with an initial presentation of sudden flank soreness and gross hematuria. Contrast-enhanced abdominal CT showed marked urine leakage in the ureteropelvic junction (UPJ). Ureteroscope cannot identify any tumor or obstructive lesion in the ureter. She underwent conservative treatment with double-j stent placement, and the leakage disappeared after 8 weeks treatment. CT scan diagnosis, conservative therapeutic approach, and follow-up will be discussed.

NDP30:
ACUTE INFRAVESICAL OBSTRUCTION RESULTS AS TEARDROP SHAPED BLADDER CALCULI

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A 36-year-old man was visited emergent department with the chief complaints of dysuria, frequency urination, lower abdominal pain during micturation and oliguria. Plain radiography showed one teardrop shaped bladder stone shadow: one as 2.14 × 1.07 cm in size. Abdominal sonography disclosed vesicle stone completely impact the bladder outlet. Endoscopic vesicolithotomy was performed. The stone was fragmented to smaller particles with pneumatic lithotriptor.
Although a bladder stone is not rare, this case is interesting for differentiated diagnosis of low urinary tract symptoms in young man at emergent department.

NDP31:
A HUGE RENAL CELL CARCINOMA-CASE REPORT

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Purpose: A case of renal cell carcinoma (RCC) presenting to the Emergency Department with pyrexia and gross hematuria is discussed.

Materials and Methods: An 82 years old female patient presented to the Emergency Department with feeling unwell, pyrexia, gross hematuria, nausea and abdominal pain. She gave a history of type 2 Diabetes mellitus with regular follow-up in our hospital. A large right renal mass was detected near 4 years ago. However, she and family refused operation since then due to old age. On examination she looked weakness. A mass was palpable in the right upper quadrant and lumbar region. Liver and spleen were not palpable. There were no signs of peritonitis. Her pulse rate was 121/minute, BP 189/104 and temp 39.3 degree. She had blood tests in the Emergency Department which revealed the following: Hb 15.6 g/dL, WBC 11,400 and platelets 202,000. Electrolytes were as follows: Na 136 mmol/litre, K 3.3 mmol/litre, BUN: 12, creatinine: 0.8, blood sugar: 213. Chest X ray showed 1) Mild coarse and crowding lung markings, some infiltration in bilateral lungs; but no focal active lung lesion. 2) Borderline cardiomegaly and mild tortuosity of aorta with some calcified atheroma plaques of aortic arch wall.. The patient had ultrasound scan which showed mass in the right kidney. Computerised tomography (CT) scan image of abdomen showed anterior upper pole tumor 9.5 x 12 x9.0 cm in size with heterogeneous enhancement and area of necrosis. Extension to perirenal fat and renal sinus fat but not Gerota fascia. Positron emission tomography (PET) revealed: 1. F-18 FDG avid lesion in the left thyroid, malignancy should be considered. 2. Right paraaortic lymph node metastases should be considered.
She underwent right-side radical nephrectomy after full staging procedures and appropriate investigations.

NDP32:
BACTERIAL EMPHYSEMATOUS PROSTATIC ABSCESS – A CASE REPORT

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Purpose: We present a case of emphysematous prostatic infection complicated with multiple organs abscess by Klebsiella pneumoniae.
Materials and Methods: A 47 year-old male patient suffered from uncontrolled diabetes. Four days before admission, he had fever and general weakness. He visited our emergent department after empirical treatment at local clinic. After admission, intensive care was given due to diabetic ketoacidosis and septic shock. Although multiple drains for liver and lung, spiking fever persisted. Sequential CT showed air and abscess in the prostate region. Urgent transurethral prostate incision was done to drain the abscess. Afterwards, the general condition became stable. He was discharged with oral antibiotics and antidiabetic drugs. After one year follow-up, the patient kept uneventful condition with tight diabetic control.
Conclusion: Emphysematous prostatic abscess is an unusual acute disease with high morbidity and mortality. The predisposing factors include diabetes mellitus, hepatic cirrhosis, and intravesical obstruction. CT provides a good tool for immediate diagnosis. Treatment of prostatic abscess includes parenteral antibiotics and abscess drainage. Transperineal needle aspiration, transrectal needle aspiration, open perineal incision, and transurethral resection or unroofing are available routes for drainage.