mediastinum, head, and neck. We would like to present a 17 years old female with a huge pelvic mass extent to right upper quadrant of abdomen size measures in 21x5.4x8.5 CM. Debulking surgery was performed and revealed a huge ganglioneuroma of retroperitoenum, the clinical presentation, special image and pathological picture and our experience in management of huge retroperitoneal tumor with literature review.

NDP119:
CASE REPORT –PENILE METASTASIS OF PROSTATE ADENOCARCINOMA WITH PRIAPISM AS THE INITIAL PRESENTATION

Hung-Yi Chen, Chun-Te Wu, Wen-Hsiang Chen, Cheng-chia Lin, Shian-Shiang Huang, Cheng-Feng Lin. *Divisions of Urology, Department of Surgery, Chang Gung Memorial Hospital, Keelung, Taiwan*

Case report: A 95-year-old male has underlying disease of severe prostate hyperplasia, abnormal serum prostate-specific antigen (PSA: 18.41ng/dl) and hardness digital rectal examination were noted. Because of multiple comorbidities and bed ridden status, further prostate malignancy survey cannot be performed. Patient has long-term Foley catheteration for difficult urinary voiding treatment. He hospitalized for antibiotic treatment under the impression of urinary tract infection with initial present by gross hematuria and pyuria. However, painful priapism with adequate glans circulation noted for one week. Bedside cavernosal aspiration revealed no blood content but only debris. No evidence of sickle cell anemia via hematological study. Dorsal slit with cavernosal biopsy was performed for symptoms relief and differential diagnosis under local anesthesia. The priapism and pain improved after the shunting procedure was done.
The following pathological report of biopsy tissue showed poorly differentiated adenocarcinoma. Metastatic prostate adenocarcinoma was proved by the immunohistochemical (IHC) stain which disclosed P504S positive. Further bone scan revealed no obvious bony metastasis, patient cannot complete pelvic magnetic resonance imaging (MRI) study because of poor general conditions. This patient died of another episode of pneumonia related sepsis progression l month later.
Conclusion: Prostate adenocarcinoma metastasis by pelvic lymphovascular route with the presentation of lymph edema. Gross hematuria and urine retention are also common in the advanced disease. We reported an uncommon case of non-ischemic priapism by prostate cancer penile metastasis.

Laparoscopy

NDP120:
A CASE REPORT OF ROBOTIC ASSISTED LAPAROSCOPIC RADICAL CYSTECTOMY WITH Y POUCH ORTHOTOPIC ILEAL NEOBLADDER CONSTRUCTED USING NONABSORBABLE ENDO GIA STAPLES

Yuli Lee [1,2], Lipin Chiu [1,2], Yuwei Lai [1,2], Thomas Y. Hsueh [1,2], Yi-Chun Chiu [1,2], Shiou-Sheng Chen [1,2], Allen W. Chiu [1,2]. [1] *Divisions of Urology, Department of Surgery, Taipei City Hospital, Taiwan;* [2] *National Yang-Ming University, School of Medicine, Taiwan*

Background: Laparoscopic-assisted radical cystectomy with Y pouch orthotopic ileal neobladder constructed using nonabsorbable titanium staples was early reported in 2006. Herein we present the case of robotic assisted laparoscopic radical cystectomy with Y pouch orthotopic ileal neobladder constructed using nonabsorbable endo GIA staples and a brief literature review.
Case Report: A 65-year-old man was admited because of pianless gross hematuria. Cystoscopy showed multiple focal cauliflower tumor. Transurethral resection of bladder tumor was performed. The pathological report showed urothelial carcinoma with muscle invasion. Computed tomography showed diffuse bladder wall thickness and no obvious lymph node metastasis. We performed robotic assisted laparoscopic radical cystectomy with U-shaped orthotopic ileal neobladder constructed using nonabsorbable endo GIA staples. In our procedure, a 50-cm ileal segment is arranged in a U shape with two segments of approximately 20 cm and two afferent limb of 5 cm. An opening is made at the lowest point of the U-ileal segment on its antimesenteric border. The jaws of the endoGIA stapler are accommodated within the bowel loop and fired as low as possible, bringing together and detubularizing of each arm of the U. To complete the pouch detubularization, another small opening is made at the bottom. Then use the endo GIA, completing the U pouch. Then performed the anastomosis of the open ends of the U shape and the cutting end of urethra.Total operation time is 290 minutes and no intraoperative complication. The patient was discharged uneventfully. Post operation one year follow-up, no bladder stone and no renal function deterioration were noted
Conclusion: Robotic assisted laparoscopic radical cystectomy with U-shaped orthotopic ileal neobladder constructed using nonabsorbable endo GIA staples seem a feasible, safe and rapid procedure.