NPDP107: ABDOMINAL CHANGE OF MEDIAN RAPHAEL CYST AFTER SEXUAL INTERCOURSE IN A MIDDLE-AGED MAN

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Purpose: Median raphae cysts are benign lesions that present anywhere between the urethral meatus to the anus, along midline of the ventral side. Discover commonly during childhood or adolescents. It is usually asymptomatic or unrecognized during childhood. The cysts become symptomatic with advancing age due to infection or trauma. Here we present the case of middle age man, who presented abscess change of median raphae cysts after sexual intercourse.

Case Report: A 43 year old male patient came to our OPD with the complaint of 2 x 2cm protruding mass noted along the urethral meatus. A small cystic lesion was presented since several years ago without symptoms and or increasing in size. Until, a month ago, after having sexual intercourse, he noted the cyst grew it symptomatic and or increasing in size. Until, a month ago, after having sexual intercourse, he noted the cyst grew it symptomatic and or increasing in size. The cystic mass with excision was done at OR. Pathologic report revealed a median raphae cyst with abscess change.

Conclusion: Median raphae cysts are uncommon benign congenital lesions that can develop at any site along the midline of the ventral side of the male genital area, from the urethral meatus to the anus and the perineum. The most common location is the penile shaft and the parametral position. They have been rarely reported in the glans of penis and the scrotum. Most of the them, are asymptomatic or unrecognized during childhood, may progress slowly and become symptomatic during adolescence or adulthood. The more distal the location, the bigger the size, greater will be the manifestation of the symptoms, such as pain (may be due to infection or trauma), urinary difficulty, hematuria, hematospermia and difficulty in having sexual intercourse. According to the histopathological findings, median raphae cysts can be classified into four types: urethral (55%), epidermoid (5%), glandular (3%) and mixed (36%). Treatment should be considered for the symptomatic lesions and for cosmetic purposes. Aspiration alone did not recommend due to high recurrence rate. Excision followed by primary closure, remains the optimal treatment option.

Other

NPDP108: PATIENTS DISCHARGED FROM UROLOGIC WARD RETURN TO EMERGENCY DEPARTMENT IN 72 HOURS: THE CLINICAL FEATURES

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Purpose: It is an important issue about immediate emergency department return after discharge from ward. It not only costs massive social resources, but also distracts patient, family, and doctors and nurses. Besides, potential medical problem may exist in those patients, and it may affect satisfaction of treatment. Reviewing those cases to figure out the cause of emergency department return may improve the quality of medical care.

Materials and Methods: This retrospective study included patients who were discharged from urologic ward in NCKU hospital, and returned to our emergency department in 72 hours between 2015/01/01 - 2015/12/31. We reviewed medical records during admission and emergency department including further management and clinical course. In 2015, in our hospital, the patients number of discharge from our hospital is 5207, and returning to emergency department in 72 hours of entire hospital is 1287 (2.5%). However, the number of discharge from urologic ward is 2021, and 67 visits (3.3%) of emergency department return is recorded, and it is higher than the average of our hospital.

Results: Among 67 emergency department visits, most patients came back to emergency department during the first two days. 25 visits (37.3%) are within in the first 24 hours, and during second 24 hours, 24 visits (35.8%) are recorded. 42 visits are old age (more than 65-year-old), and 61 visits are male. 3 patients came back to emergency department repeatedly. The most common cause of emergency department is acute urine retention (28.4%). The second one is bleeding including gross hematuria (17.9%). Further management including medication (43.3%), invasive intervention (55.2%), admission (urologic department or other departments) or surgery (1.5%) are also collected in this study.

Conclusion: Reviewing those immediate emergency department return after discharge from urologic ward may be helpful for medical quality improvement. Further health education and evaluation material before discharge can be developed based on the results of this study.

NPDP109: NEW DESIGNED SURGICAL GOWN FOR PATIENTS

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Purpose: Some defects of the original surgical gown for patients in our hospital were found. We modified the original surgical gown for patient to a new form to fit the clinical demand. We would like to know if the new designed surgical gown for patient is better than the original one.

Materials and Methods: The style of our original surgical gown for patients is Japanese kimono style. The original surgical gown was usually on backwards for the surgical demand. We modified the original surgical gown for patient to a new form with plastic zippers. The zippers were set from lateral side of bilateral sleeves opening along shoulder to collar and over bilateral side seam. Besides, we used Velcro to protect zipper sliders. We compared the difference of these two kinds of surgical gown for patient in clinical use.

Results: The patient revealed that the new designed surgical gown is more comfortable and easy to wear than the original one, because the new one is on frontwards and the patient's neck doesn’t be compressed by the collar of the surgical gown. However, the original surgical gown was on backwards and the patient's neck was compressed by the collar of surgical gown and the patient felt discomfort. The zipppers on the new designed surgical gown can be unzipped to expose the patient with an adequate field for operation and anesthesia according to the different surgical procedures. Other parts of the patient can still be covered by the new designed surgical gown to prevent the patient suffering from hypothermia during preparation of the operation. Compared with the original surgical gown, the patient could be redressed with the new designed surgical gown easily.
after operation. Besides, the new designed surgical gown is also suitable in the ward. Because the zippers were set from lateral side of bilateral sleeves opening along shoulder to collar, the patient could take off the surgical gown easily when there was an injection line in the patient’s forearm.

**Conclusion:** The new designed surgical gown for patients is suitable for every kind of operations to expose adequate operative field without making the patient suffering from hypothermia and is easy to put on and take off when there is an injection line in the patient’s forearm. The new surgical gown for patients may have the benefits for the patients and nurses in clinical care.

**NDP110: POSTULATED ALGORITHM FOR URINARY BLADDER DYSFUNCTION OF PATIENTS AFTER PELVIC MALIGNANCY TREATMENT – SHORT TERM REPORT OF A LOCAL HOSPITAL**

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**Purpose:** The primary function of urinary bladder is for urine storage and voiding. Treatment for pelvic organ malignancy may deteriorate the originally normal bladder function. The aim of this study is to postulate a clinical steps for managing bladder dysfunction of the patients who had treatment for pelvic malignancy.

**Materials and Methods:** A retrospective chart review study was performed. From the urodynamic studies records, patients with pelvic organ malignancy after treatment (surgery or radiation) were enrolled. Patients’ gender, age, causes of malignancy, were recorded and analyzed. Patients receiving urodynamic studies with benign causes were excluded. A possible flow chart to manage the bladder dysfunction was proposed by reviewing literature.

**Results:** From January 2014 to March 2014, there were 77 patients eligible for urodynamic analysis. Pelvic organ malignancies included prostate (31/77), bladder (18/77), colonic (21/77), and cervical (7/77) origin. The urodynamic studies were demonstrated by uroflowmetry and cystometry. In uroflowmetry (53 cases), maximal urine flow rate ranged from 6 to 17 ml/sec (mean 11.8). In cystometry (27 cases), most of the bladder contractility showed detrusor areflexia (11/27) followed by detrusor hyper-reflexia (7/27), hyper-reflexia (5/27) and normoreflexia (4/27). Several methods were postulated. Behavioral therapy, weight loss and pelvic muscle exercise, might improve neurogenic dysfunction. Medications consist of antimuscarinic agents and newly developed B3-adrenergic agonist. Mono-therapy or combined medications is based on the improvement of the patients. Side effects of B3-adrenergic agonist include hypertension, cardiac arrhythmia, and urinary retention. After refractory to prior management, invasive procedures including treatments with onabotulinumtoxin A, percutaneous tibial nerve stimulation, and sacral neuromodulation are available options.

**Conclusion:** This is a short term report. An algorithm will be drawn for clinical application. Further study for longer and larger scale is needed.

**Renal transplantation**

**NDP111: SUCCESSFUL REUSE OF A RENAL GRAFT 9 YEARS AFTER INITIAL TRANSPLANTATION – A CASE REPORT**

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**Purpose:** Kidney transplantation is still the choice of renal replacement therapy for patients with end-stage renal disease (ESRD). However, shortage of organ is still the problem worldwide. In 1993, Amado et al. reported the first case of successful reuse of a transplanted kidney. After that, only few cases report were found at English literatures. Herein, we report out experience of successful reuse of a renal graft 8 years after initial transplantation.

**Case report:** The first donor was a 40-year-old man with brain death due to intracranial hemorrhage after a traffic accident. The first recipient was a 45-year-old man and received transplantation in 2005. The immunosuppressant drugs were cyclosporin, everolimus, mycophenolate mofetil, and prednisolone.

In June 2014, the first recipient suffered from right cerebral aneurysm rupture and caused brain death. Serum creatinine level was 0.69 mg/dL. We harvested the transplanted kidney for reuse transplantation. The second recipient was a 40-year-old man who received hemodialysis for 5 years. The post-operative cause was uneventful and serum creatinine down to 1.17 mg/dL.

**Conclusion:** Our case received refuse of transplanted kidney after 9 years after first transplantation. To our knowledge, this is probably the longest reuse of orange after first transplantation. In our experience, if the transplanted organ has good function, it could be still reuse years after transplantation.

**Other**

**NDP112: SUCCESSFUL ARTERIAL EMBOLIZATION FOR SPONTANEOUS ADRENAL HEMORRHAGE: A CASE REPORT**

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**Case report:** A 53-year-old man denied any systemic disease visited ER due to sudden onset of severe right flank pain for half day. There was no past history of headache, palpitation, cold sweating, abdominal trauma, fever, nausea, vomiting, hematuria, or constipation. Physical examination found prominent tenderness over epigastric and right upper quadrant of abdomen and right costovertebral angle knocking pain. Tachycardia (117 beats/minute) and elevated blood pressure (164/89 mmHg) were noted. Complete blood count revealed leukocytosis (12900/μl) without anemia (hemoglobin, 15.7 g/dL). Abdominal and pelvic computerized tomography with and without contrast was performed which showed 15*13 cm retroperitoneal hematoma in the right suprarenal region with a contrast extravasation and focal strong enhanced lesion about 3.5*2.4 cm inside. Adrenal hemorrhage (AH) was suspected. Blood pressure drop (84/53 mmHg) with anemia (hemoglobin 10.3 g/dL) was noted 2 hours later. The blood pressure returned to 100/75 mmHg after fluid resuscitation and blood transfusion (2 bags of erythrocyte suspension). Emergent transcatheter arterial embolization (TAE) was performed 4 hours later and a branch of middle adrenal artery supplying the right adrenal lesion was identified and occluded with 3 metallic coil. The hemoglobin stabilized around 10 mg/dL and no more blood transfusion was given. The patient was discharged on post-TAE day 9 without sequelae. Adrenal study including plasma rennin activity, aldosterone, cortisol, and urine catecholamine and vanillylmandelic acid (VMA) were checked 4 months later and were normal. Follow-up abdominal CT revealed a 1.8 cm oval well-circumscribed heterogeneously low-density right adrenal mass with significant enhancement in a 4-month-interval CT and complete resolution of adrenal mass in a 26-month-interval CT.

**Conclusion:** Martin et al. analysed management of spontaneous AH associated with adrenal masses and found adrenalectomy was the major intervention in most cases (79%). Adrenalectomy followed TAE was 5% and treatment with TAE only accounted for only 2%. TAE can provides hemostasis and prevents emergent surgery which had been reported to increase postoperative mortality. Hokotate et al. reported a 82 % successful rate using TAE compared to over 90% successful rate using open or laparoscopic adrenalectomy for aldosteronoma. The successful rate in TAE for AH is still unknown, we presented a case with spontaneous AH treated by TAE successfully. In our case, we found only one branch of middle adrenal arteries supplying the adrenal mass. TAE can be used in hemorrhagic and hormone control of adrenal tumor. Pheochromocytoma was suspected during procedure of TAE due to transient elevated blood pressure. However, a 26-month-interval abdominal CT showed complete resolution of adrenal mass. In Martins et al. series, only 1 in 6 patient had complete resolution of mass after TAE and they concluded it was adrenal hematoma misidentified as adrenal tumor. The normal adrenal gland found by follow-up CT scan attested this is a case of spontaneous AH treated successfully by TAE. This case highlights the importance of TAE for