SOGUS AT GLANCE

SCIENTIFIC PROGRAM AT GLANCE

DR VASANTH KRISHNA BEST PAPER AWARD

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<td>800 AM TO 900 AM</td>
<td>Dr Jyothi Reddy prize PG paper session-I</td>
<td>Dr RAM REDDY, Dr N Srinivas, Dr Srimannaryana</td>
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<td>Dr A Tyagi, Dr DSRK Prasad, Dr B Prakasa Rao, Dr K Prasada Raju</td>
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<td>900 AM TO 1000AM</td>
<td>Asian institute of nephrology &amp;urology prize video session 1</td>
<td>Dr PVLN Murthy, Dr A V Ravi Kumar, Dr M Prasada Rao</td>
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<td>Dr Anil, Dr Ramana Kumar, Dr K Sitharamaiyah, Dr Jagdeeswar</td>
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<td>10.00to 11.00 AM</td>
<td>Dr VASANATHA KRISHNA BEST PAPER AWARD session1</td>
<td>Dr JAGDEESWAR, Dr AV Krishna Kishore, Dr K Prasad Raju</td>
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<td>Dr TV Narayana Rao, Dr Ram Reddy, Dr P Sudhakar, Dr Jayaram Reddy</td>
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<td>DR RANGANADHA RAO ENDOUROLOGY ORATION</td>
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<td>&quot;My journey through minimally invasive surgery in urology.&quot;</td>
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<td>NEUROGENIC BLADDER SURGERY TO increase outlet resistance and storage</td>
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**Introduction:** Majority of the data pertaining to Prostate cancer is from Western countries and details the parameters for predominantly Caucasian population. There is evidence from small cohort studies from India suggesting that the age specific PSA for Indian men is much less compared to caucasian population. We aimed to study the age specific PSA for Indian men.

**Objective:** To ascertain the age specific PSA of healthy Indian men.

**Methods:** All patients who attended Master health check up and had a PSA blood test at our Institute over the period between Jan 2009 and Aug 2018 were studied. All patients whose address was not from India were excluded. Patients were divided into age cohorts and median PSA was studied for each cohort. The mean PSA along with other statistical parameters were studied. along with the range and standard deviation were studied.

**Results:**

During the study period there were 30,734 men who underwent MHC at our institution. After excluding non-Indians there were 23,591 (76.8%) who formed our study cohort. The results of the preliminary analysis are as below:

<table>
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<th>Age cohort</th>
<th>Number of patients</th>
<th>Median PSA</th>
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<td>&lt;40 yrs</td>
<td>2277 (9.7%)</td>
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<td>41-50</td>
<td>5561 (23.6%)</td>
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Conclusion:
This is the largest study from India and defines the age specific PSA for Indians. This will allow us to determine the standards as well as define the PSA levels that would trigger a prostate biopsy.

**Conclusion:**

This is the largest study from India and defines the age specific PSA for Indians. This will allow us to determine the standards as well as define the PSA levels that would trigger a prostate biopsy.

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**VK 2. SEVERE UNRESPONSIVE ED– DOES LI-SWT HAS A ROLE?**
**DR. SREEDHAR KAMMELA, DR. NAVEEN ACHARYA, DR. SASHANKA,**

**DR. SREEDHAR’S KIDNEY, ANDROLOGY & I.V.F. INSTITUTES, MEHDIPATNAM, GACHIBOWLI, HYDERABAD, TELANGANA**

**Objectives:** Low Intensity Extracorporeal Shock Wave Therapy is a new and novel modality of treatment which was shown to benefit ED patients responding to PDE5is. There are many patients who have been using PDE5i for a long time without proper prescription and increasing dosage on their own. The aim of the study was to assess its effect on patients who did not respond to PDE5is after using them indiscriminately for several years.

**Methods & Study Design:** We studied 82 severe ED patients who failed to respond to PDE5i oral medication. They scored 0-2 on rigidity scale (RS) during PDE5i therapy. Each patient underwent baseline assessment of erectile and sexual function during PDE5i treatment using validated questionnaires and objective penile Doppler/ EndoPAT.
Treatment schedule included 2 sessions/week for 3 weeks (6 sessions in first phase) & repeated after a ‘3 week no-treatment’ interval. Second phase included 2 sessions/week for another 3 weeks (6 sessions) making a total of 12 sessions in 9 weeks. At each session LI-ESWT was applied on the penile shaft and crus for 3 minutes in 5 different anatomical sites, namely 3 sites on penile shaft and two sites on penile crura (one on each crus). Shock wave intensity was of 0.09mj/mm² and a pulse of 300 shocks given/site and a total of 1500 shocks were delivered. One month after end of treatment the same baseline assessment was repeated. An active PDE5i medication was then provided and final erection function was reassessed. Main endpoints for success were changes in Rigidity Scale (RS) and IIEF-ED Domain score (EDDS).

Results: Eighty two patients (36-78 years, mean age 58.5) with an initial average EDDS of 8.9±0.92 (on PDE5i therapy) were analyzed. 71 patients completed a full 12 week treatment course. After one month their EDDS markedly improved to an average of 13.4±1.07 without medication. At the end of active PDE5i treatment the mean EDDS was 21.61±1.26 (an increase of 12.70 points, p<0.001) and 79% of patients had an RS of 3 or more (p<0.001). 19 patients were normalized with the use of PDE5i & all penile Doppler/FMD parameters significantly increased and no adverse events were reported.

Conclusions: In treating severe ED patients who failed to respond to oral medication, LI-ESWT is a useful modality. This study emphasizes the physiological effect that LI-ESWT has on hemodynamics of erectile mechanism.
Methods: 32 patients of chronic kidney disease underwent renal transplant from live donor and deceased donor in last one year in our institute. 14 received kidneys from live related donors and 18 received kidneys from deceased donors. In 14 out of 18 deceased donors, kidney harvesting was done in our institute from brain dead patients and in rest of the 4 cases kidney was harvested at a distant place.

Results: Most of the patients had smooth intraoperative and postoperative course. One patient developed DVT and Lymphocele, one developed fungal infection, one developed delayed graft function and one developed Acute Rejection

Conclusion: Deceased donor renal transplants outnumber live related transplant at our centre since two years. We found almost similar short term outcomes of both live related and cadaver kidney transplants at our institute.

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VK 4.A PROSPECTIVE COMPARATIVE ANALYSIS OF STONE COMPOSITION BY DUAL ENERGY CT SCAN AND STONE ANALYSIS BY FOURIER TRANSFORM INFRARED SPECTROSCOPY (FTIR)

DR. K. SESHU MOHAN, DR. V. SURYA PRAKASH, DR. D. SRIKANTH REDDY, DR. MILAN PATEL, DR. RAJESH REDDY

YASHODA HOSPITAL, SOMAJIGUDA, HYDERABAD, TELANGANA, INDIA

Introduction:
In addition to detecting stone location, stone size, and stone density, dual-energy computed tomography (DECT) has recently been used to characterize the chemical composition of urinary stones. The dual energy CT has been reported as having a near 100% sensitivity and specificity for characterizing the chemical composition of renal stones more than 3 mm. Dual energy CT is expected to replace conventional single energy CT (SECT) as an important imaging modality in evaluating patients with suspected urinary calculi.

The purpose of this study is to evaluate the capability of DECT to assess the composition of urinary calculi and to compare with standard stone analysis by FTIR method. In this prospective study comparing biochemical stone analysis by FTIR spectroscopy vs Stone composition predicted by DECT, 25 patients were studied.
from October 2017 to September 2018. The results of DECT and stone analysis by FTIR are discussed.

Since calcium calculi are the most frequent, we specifically aimed at sub-differentiation of calcium calculi and detecting Calcium oxalate monohydrate stones (which are relatively resistant to ESWL).

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**VK5. CONSTIPATION IN CHILDREN WITH LOWER URINARY TRACT SYMPTOMS (LUTS)**

**MALLIKARJUNA REDDY N, HARI KRISHNA M, JAYARAJU J, BHARGAVA REDDY K V, VEDA MURTHY REDDY P,**  
**DEPARTMENT OF UROLOGY AND RENAL TRANSPLANTATION, NARAYANA MEDICAL COLLEGE, NELLORE, ANDHRA PRADESH**

**Introduction** – Constipation is a common entity in pediatric patients commonly missed. Bladder and rectum have a common embryological origin with similar autonomic and somatic innervations, dysfunction in one may influence the function of the other, including mechanical hindrance. BBD is a clinical syndrome defined by the coexistence of functional constipation and lower urinary tract symptoms (LUTS). The diagnosis of BBD is typically based on patient history and physical examination. We looked at treatment of constipation and its effects on bladder dysfunction.

**Aims and Objective:** To evaluate outcomes following treatment of constipation in patients with pediatric age group presenting with Lower Urinary Tract Symptoms (LUTS).

**Methods:** This is a retrospective study conducted at Department of Urology Narayana medical college, from October 2017 to May 2018. Seventy one pediatric patients presenting with Lower Urinary Tract Symptoms (LUTS) were studied in terms of age, gender, LUTS along with any associated symptoms. Constipation was assessed by history, Bristol stool chart, X-ray KUB and MCUG if required. Bristol stool chart less than type 3, Rectal diameter more than 3 cms, dilated RT colon and caecal diameter > 3 cms were all considered constipated. Outcomes were analysed after treatment of constipation. All patients were treated constipation with bowel regime (Toilet Training, Dietary modification, Laxatives comprising PEG powder as 1st line medical management and Lactulose as second line milk of magnesia preparations as third line).

**Results:** Mean age was 6.33 ±3.64 years with a range of 2 - 14 years. Constipation was found in 42% of the pediatric patients with lower urinary tract symptoms. Urinary incontinence was present in 22%. Faecal incontinence was there in 12%,
mean rectal diamiater in plain radiographs was 4.2 cms .mean ceecal diameter was 3.4 cm.Treating constipation improved bladder outcomes in 77 % of children . 6 patients were identified as functional non retentive faecal incontinence with improvement on laxatives . 2 patients ultimately required surgery(MACE).

**Conclusion:** Constipation is frequent and underlooked problem in pediatric patients having urinary symptoms. Treatment of constipation should be first line before intiation of Anticholinergics

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**Material and Methods:**
We did a prospective study in our center form April 2015 to June 2018.

**Inclusion**: all preputial flap repairs done at our hospital

**Exclusion**: cases operated outside our center

Preoperative workup included a through examination to rule out any local skin diseases , retrograde urethrogram and urine culture. All cases were operated by a single surgeon. Patient in lithotomy urethra was mobilized and stricture segment was layed open. Penis was degloved, preputial flap was raised over the dörtus fascia upto the base of the penis. Flap was mobilized to stricture segment with the arc of rotation. Urethral margins were sutured to the skin flap margins.
over a foleys catheter. Post operatively patients were followed up at 3 weeks for pricatheter RGU followed with foleys removal and again followed up at 1 month and every 3 months until 1yr and every 6 months for next 1 yr and yearly there after. During each visit uroflowmetry and urethroscopy were done.

Results:
we had a total of 5 cases of preputial flap repair over 3 years. Mean operative time was 210 +/- 30min. Mean follow up was 29.4 months. No case had recurrent stricture disease. One patient had leak at pericatheter RGU which was managed by prolonged cathertization. All cases had post void dribbling which was managed by educating about the massage after voiding.

Conclusion:
Preputial flap urethroplasty has a good results with long segment stricture urethra. Raising the flap requires expertise. It’s a good alternative when the buccal mucosa is not possible.

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VK7. USE OF AUTOLOGUS FASCIA LATA AS TRANS OBTURATORY TAPE (TOT) SLING FOR SURGICAL MANAGEMENT OF FEMALE STRESS URINARY INCONTINENCE: A NEW CONCEPT AND ITS FEASIBILITY
AUTHOR: DR. PRASADA RAO M, VISAKHAPATTANAM, ANDHRA PRADESH

Introduction:
Urinary incontinence is a common disease with a prevalence as high as 30% in women of 30-60 years. Stress Urinary Incontinence (SUI) constitutes up to 50% of this. Midline urethral slings especially Trans Obturator Tape (TOT) sling using prolene mesh is very well accepted treatment modality but not without complications like mesh erosion, dyspareunia etc.. In view of these complications some international guidelines cautioned about usage of mesh for pelvic organ prolapse.

Objective:
To assess the use of autologus fascia lata as Trans-Obturator Tape (TOT) Sling for Surgical Management of female Stress Urinary Incontinence(SUI) in terms of post-operative results, cost effectiveness, acceptance and complications.

Materials and methods:
Between April 2015 – March 2018 a total of 14 patients who are otherwise offered surgical treatment for their SUI were included in the study. Patients were explained about different options of treatment for SUI and use of this new concept of fascia lata graft and complications. Perioperative events were noted. All patients were followed up at 2 weeks, 3, 6, 12 months intervals. Results & complications were evaluated with each visit. Approximately 30x3 cm sized facial lata graft harvested from thigh. A conventional tension free outside - in TOT surgery was done using this graft as sling instead of mesh and either ends of the graft were fixed to subcutaneous tissue with 2 ’0’ prolene stitch at exit site of TOT. On 3rd post operate day FC removed and patient were discharged.

**Results:**

Mean age of patients was 34.6 years (range 32-58 years). 12 patients had genuine stress leak. The other 2 patients had mixed component also with predominant stress leak. Average duration of symptoms were approximately 3 years. Operative time was 45 minutes +/- 30 mts. Hospital stay was 3-5 days. Regarding cost, all the patients were saved the cost of mesh. After removal of F.C all patients were continent in all follow up visits. Two patients had urgency, that could be managed with anticholinergics. None of the patients had complications related to surgery are related to graft till the end of one year follow up.

**Conclusions:**
Fascia lata can be considered as a safe alternative to mesh for TOT Sling surgery for genuine stress urinary incontinence with good results and without fear of mesh related complications. Needs a Long term follow up to further validate this new method.

**Session 2:**

**VK 8. PROSPECTIVE STUDY OF COMPLICATIONS OF RIRS BY MODIFIED CLAVIEN-GRADING SYSTEM**

**DR SIDDHALINGA SWAMY, PREETI UROLOGY HOSPITAL, HYDERABAD**

**Aim and objective:**
RIRS is one of the most common procedure done for renal stone. Many studies have shown fewer complications in RIRS than conventional PCNL. However RIRS is not without complications. We did a prospective study of RIRS done at our hospital to know the complications by modified clavien grading system and the factors affecting it.

**Material and methods:**

Prospective study done from the period of May 2016 to May 2018.

All RIRS cases done at our hospital during this period were included in the study. Data regarding demographics, preoperative and perioperative and postoperative period were recorded. Patients with tight ureter underwent DJ stenting followed by RIRS after 15 days. Pre operative positive urine cultures were treated with IV antibiotics and RIRS was done once the urine culture was negative. Ureteral access sheath was used in most of the cases except in few pediatric cases. Patients who require relook RIRS were posted 15 days post procedure with a negative urine sample for culture and sensitivity. Four different flexible scopes were used over the study period with quanta 30W laser machine. Irrigation was done using 50ml syringe. Input and output volume of irrigation were recorded. DJ stent was placed in all the cases postoperatively. Stent was removed at 2 weeks. All patients were followed upto 30 days post procedure and complications were recorded.

**Results:**

We have a total of 560 cases of RIRS over 2 years. Stone free rate without relook was 86% and with single relook 96%. We had over all 30% complication rate. G1- 69.5%, G2- 20.4%, G3a- 2%, G3b- 1%, G4- 0. Most of the patients had mild haematuria following RIRS in whom preoperative DJ stent was not placed and also in whom there was reduced return of irrigation fluid. Patients with reduced outflow also complained for more pain postoperatively requiring prolonged analgesics. On univariate analyses positive urine culture, mean operative time, DM, stone size affected the complications. Multivariate logistic regression demonstrated positive urine culture, operative time, DM, irrigation outflow, stone more than 2 cm were associated with higher complication rate.

**Conclusion:**

Most of the RIRS complications were of lower Clavien grades. No major complications were seen. Preoperative positive urine culture, DM, stone burden, reduced irrigation outflow were associated with higher complication rates.
MINIMAL INVASIVE PARTIAL NEPHRECTOMY FOR T1B RENAL TUMORS: TRIFECTA OUTCOMES - SINGLE INSTITUTIONAL EXPERIENCE

PRESENTING AUTHOR: DR. BHAVATEJ ENGANTI CO-AUTHORS: MALLIKARJUNA C, PURNACHANDRA REDDY, MOHD TAIF BENDIGERI, DEEPAK RAGOORI, MOHD. SYED GHOUSE, PABITRA K MISHRA.

INSTITUTE: ASIAN INSTITUTE OF NEPHROLOGY & UROLOGY, HYDERABAD, INDIA.

Introduction: Partial nephrectomy is the standard of management for T1a renal tumors. However, its role and consensus in the management of T1b renal tumors is not clear. It is preferable to perform partial nephrectomy even in T1b tumors wherever feasible, especially by minimally invasive approach.

Objective: To analyze the feasibility and trifecta outcomes of minimal invasive partial nephrectomy for T1b renal tumors. Patients and methods: We retrospectively analysed patients who underwent minimal invasive partial nephrectomy at our institute between January 2015 and June 2018 for T1b renal tumors. Patient demographics and perioperative data was analysed for the feasibility of the procedure in T1b renal tumors. Complexity of renal tumors was assessed by R.E.N.A.L. scores. Trifecta was defined as a combination of warm ischemia time less than 25 minutes, negative surgical margins and no perioperative complications. Patients with a minimum follow-up of 3 months were included in the study. The data was compared with the contemporary data in T1a renal tumors.

Results: Total 138 patients underwent minimally invasive partial nephrectomy (78 laparoscopic and 60 robotic assisted). Of these, 59 and 79 patients were in T1b and T1a groups respectively. The demographic parameters were comparable between T1a and T1b patient groups. The mean R.E.N.A.L score was 8 and 6 for T1b and T1a groups respectively. Mean warm ischemia time was 19 min (16 to 29) in T1b group to 16.5 min (14 to 28) in T1a group. Surgical margins were negative in both the groups. Perioperative complications were noted in 12 (20.3%) patients in T1b group versus 13 (16.4%) patients in T1a group. The rate of achievement of Trifecta was 64% and 68.4% in T1b and T1a groups respectively. None of the parameters had any statistically significant difference.

Conclusion: Minimally invasive partial nephrectomy is a feasible procedure for T1b renal tumors with acceptable trifecta outcomes and the results were comparable with T1a renal
INTRODUCTION
Ectopic insertion of the ureter is defined as abnormal insertion of the ureter, usually distal to the trigone into the urethra in male in approximately 50% of cases. Other sites include the seminal vesicle (approximately one-third), vas deferens, bladder neck, prostate and epididymis while the urethra and vagina are commonly affected in females. Ectopic insertion of the ureter in the genital tract is a rare anomaly. Its incidence, as reported by Fraser, is about 1:130000. It is more common in females and is usually associated with incontinence, leading to the diagnosis, while in males, it is present with infection.

CASE
A 26 years old male presented with the complaints of painless hematospermia for 4 years associated with ejaculation. Terminal hematuria for 2 days which is on and off. There no history of fever, no history of vomitings. There are no lower urinary tract symptoms of irritation or obstruction. There is no history of tuberculosis exposure. He is married 5 years back and is having 2 children. Abdominal examination did not reveal any abnormality. Penis external urethral meatus and both scrotum are normal. A working diagnosis was made by different modes of investigations. Ultrasound shows cyst in the right seminal vesicle. 24x18 mm cortical cyst in upper pole of right kidney. Seminal culture shows no bacterial growth. Montoux is negative. Viral markers for HIV, HBSAG and HCV are negative. Transrectal ultrasound (TRUS) shows 1.6x1.2 cm cyst in the right seminal vesicle and left is normal. TRUS guided aspiration of the cyst is done and fluid analysis was negative for cytology and AFB, culture was positive for pseudomonas growth. Planned for surgery and after consent, we did upper moiety along with ureter and seminal vesicle excision and sent for HPE, report came as benign seminal vesicle cyst.

DISCUSSION:
There is an association between congenital anomalies of the seminal vesicle and urinary tract anomalies due to their close embryological relationship. In men, ectopic ureteral implantation into the seminal system tends to present with peak incidence in the third decade of life through symptoms associated with voiding, ejaculation, or pain of the perineum or genitals. Ectopic ureter draining into the genital system is a rare entity and results from a more cranial origin of the ureteral bud from the mesonephric duct with resultant ureteral stump opening in the
mesonephric duct derivatives (seminal vesicles, ejaculatory ducts, or vas deferens). The inadequate stimulation of metanephrogenic blastema by the ureteric bud results in renal maldevelopment. Zinner syndrome represents a specific entity along the spectrum of ureteral malformation and renal maldevelopment in males. It is defined as the triad of unilateral renal agenesis, ipsilateral seminal vesicle cyst, and ejaculatory duct obstruction has been reported in literature, but there is no renal atrophy and ejaculatory duct obstruction in our case. Diagnosis is made by at the time of sexual activity, which in our case is hematospermia. The diagnosis can be made by urography, voiding cystography, ultrasonography, computed tomography, and MRI. Treatment of seminal cyst is reserved only for the symptomatic cases and is managed by surgical excision of ectopic ureter along with the cyst.

CONCLUSION:

There is an association between genital tract malformation and renal maldevelopment related to their close embryonic origin. We report a rare case of right ectopic ureteral insertion into the SV associated with ipsilateral upper moiety dysplasia. The diagnosis was suggested by CECT and confirmed on seminal vesiculography and pathology.

VK 11. PROSTHETIC GRAFT FOR URETHRAL SUBSTITUTION FOR PATIENTS WITH URETHRAL LOSS

VEDAMURTHY REDDY P, SUDEEP B, HARIKRISHNA M, BHANUTEJA REDDY P, PAVAN AP, PARAG, RAJAN BANSAL, RAJKUMAR, KARTHIKESH, JAYARAJU J, BHARGAV REDDY KV, N MALLIKARJUNA REDDY.

NARAYANA MEDICAL COLLEGE, NELLORE, ANDHRA PRADESH – 524003.

Introduction: Patients who have had multiple surgeries for urethral reconstruction or Urethral cripples are difficult to treat. The options for treatment are limited as the penile skin, local skin flaps, grafts and buccal mucosa are utilised multiple times. The options are to place them on long term SPC or perineal urethrostomy. We present the usage of PTFE grafts to bridge the urethral gap in these cases.

Materials: We performed this procedure in 2 cases. IRB approval was taken for the procedure.

Case 1: 31yr male had inflammatory stricture of the urethra. He was operated 5 times. The local skins, penile skin, were utilised. The buccal mucosa was harvested twice for the same. There was loss of urethral plate from the penoscrotal junction to the proximal bulbar urethra. The proximal urethra as a
perineal urethrostomy was strictured necessitating regular self dilatations. The perineal skin had BXO changes. Following IRB approval it was decided to bridge the urethra with PTFE graft. We present 1 year follow up of the graft which did not show urothelial proliferation.

Case 2: 70yr male with PFUDD and bilateral hip replacement for fracture was taken for Progressive perineal urethroplasty. Following all maneuvers the was a gap of 3cm. This gap was bridged by interposing PTFE graft.

Results: The early results show the graft patent without urothelial proliferation in short term follow up.

Conclusion: Prosthetic grafts for Urethra could be seen as an alternative in cases who need salvage.

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**VK 12.SUPINE MINI PCNL: INITIAL EXPERIENCE**

**Karthik Tanneru**

**PES Institute of Medical Sciences and Research**

**INTRODUCTION AND OBJECTIVE:**

PCNL is the most commonly performed procedure for renal calculi. Most of the PCNL are performed in prone position. World wide only 20% of PCNL are performed in supine position. The reason for this is we are never taught to perform PCNL in supine because of the fear of perforating colon in supine position. There are many advantages of performing PCNL in supine compared to Prone position. We want to assess the safety and effectiveness of supine mini PCNL

**METHODS:**

All the patients who are admitted in department of urology, PES medical college for PCNL are included in the study to assess the safety and efficacy of supine PCNL. All the cases are performed in supine using valdivia- Giusti position. The tract dilation was either 16F or 18F. No PCN was kept if tract dilatation is 16F. We noted the time to renal access and stone clearance, total operative time and post operative complications.
RESULTS:

A total of 22 cases are done till date. Initially the time to get the renal access was long. After modifying the patient position the time to renal access was significantly reduced. We are able to achieve complete clearance in all the cases. None of the patients had colon injuries or bleeding in the post operative period.

CONCLUSION:

Supine PCNL is a safe and effective alternative to Prone PCNL. The operative time can be reduced as it obviates the need to position the patient in prone, and the time to remove the fragments as they are drained with gravity flow of irrigation fluid. We need further study to validate results in large patient group.

VK 13.MANAGEMENT OF SYMPTOMATIC UROLITHIASIS DURING PREGNANCY- OUR EXPERIENCE
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Srinivasa kidney & maternity centre, Warangal

Introduction

Kidney stones afflict 10% of the population during their lifetime and over the past two decades this statistic has risen, thought to be caused by diet, climate changes, and a concurrent rise in comorbidities like diabetes and obesity. This increase in stone events has been quite dramatic for women and incidence is now close to equal between sexes, while previously it was far more common in men. While this rise has not necessarily been observed in pregnant females, this population is still affected by kidney stones, which occur in 1 in 200–1,500 pregnancies.

The top cause for nonobstetric hospital admission during pregnancy is acute urolithiasis. Anatomical and pathophysiological changes occur in the pregnant female to alter the urinary environment. Elevated progesterone and mechanical compression cause urinary stasis. Increased glomerular filtration rate, calcium supplementation, and increased circulating Vitamin D levels lead to elevated
urinary pH and hypercalciuria. Uric acid, sodium, and oxalate, all lithogenic factors, also all have increased urinary excretion during pregnancy. These changes promote calcium phosphate stone formation. Up to 75% of pregnant patients with kidney stones have calcium phosphate stones in contradistinction to the general population where calcium oxalate is the most common stone type.1

Renal colic has been associated with multiple potential risks to mother and fetus including preterm labor, preterm delivery, preterm premature rupture of membranes, recurrent pregnancy losses, and mild preeclampsia, but data are somewhat mixed. These potential complications make accurate diagnosis crucial.

MATERIALS AND METHODS
in our study, there are total of 17 cases of pregnant women who had been treated for urolithiasis at our center from January 2017 to may 2018. Observations included age, presenting symptoms, diagnostic methods, calculi location, urologic intervention, stone size, trimester of diagnosis, and postpartum treatment. The diagnosis of urolithiasis was made on the basis of clinical presentation, presence of microscopic hematuria in urine analysis, USG abdomen and KUB. Fetal status is examined by obstetric examination. Complications of intervention explained to the patients.

RESULTS
The patient ages ranged from 20 to 31 years, and five patients had history of stone disease. The diagnosis of urolithiasis was 3 in first trimester, 5 in second trimester and 9 in third trimester. 6 patients were on right side and 11 patients on the left side.

Management was initially conservative in all patients. In 6 patients, a double J stent was inserted, 3 patients undergone primary ureteroscopic retrieval of stone and 3 patients underwent PCNL in postpartum period.

Of the 17 of these patients 10 had normal fullterm vaginal delivery and 1 had premature (32 weeks) normal vaginal delivery and rest of 6 underwent LSCS. All the fetuses were delivered without complications.

DISCUSSION
Diagnosis and management of pregnant women with urolithiasis is a clinical challenge. Ultrasonography is reasonable diagnostic procedure with high sensitivity. Conservative management is first choice. If conservative management is fails DJ stent insertion will relieve the majority of symptoms until definite treatment can take place after delivery.
VK 14 ROBOTIC RADICAL PROSTATECTOMY-POSTERIOR APPROACH - IS IT THE RIGHT APPROACH IN LOW VOLUME CENTERS

Dr M Gopichand, Dr Kalyan C .,Dr Shantivardhan,Dr Fraz, Dr Vinay Krishna Institute of Medical Sciences ,Hyderabad

Objective

To report the operative technique, oncologic and therapeutic outcomes, and learning curve from our initial series of over 40 patients treated by robotic radical prostatectomy-Posterior approach

Methods

Between January 2014 and May 2018, 43 patients with clinically localized prostate cancer underwent a robotic radical prostatectomy by posterior first approach. Data collection included patient age, body mass index (BMI), clinical T stage, biopsy Gleason score, and prostate-specific antigen (PSA). Operative outcome measures included operative time, estimated blood loss (EBL), and complications. Postoperative outcomes were length of hospital stay, catheter duration, pathology, margin status, biochemical recurrence, and return of continence.

Results

Mean operative time was 230 minutes with an EBL of less than 1 transfusion of blood. Initial 3 years were excluded from this study. 4 patients required conversion to open surgery. 1 patient had post operative day 1 re exploration. The average hospitalization was 5 days, and Foley catheters were removed after 15 days. 9 patients had a positive surgical margin, with a decrease from in the latter half. Posterior dissection first was used in all patients. It helped in decrease in complications.

Conclusion

Robotic radical prostatectomy is an effective treatment modality for clinically localized prostate cancer. Posterior first approach decreases the learning curve. The anatomy is much clearer in this approach and makes robotic radical prostatectomy surgery feasible even in low cancer prostate volume centers.
JR 1. A NOVEL TECHNIQUE OF LAPAROSCOPIC EXTRAPERITONEAL TUNNELING FOR CAPD CATHETER INSERTION.

Dept of Urology, Narayana Medical College, Nellore, Andhra Pradesh, India.

Introduction & Objective:
To describe laparoscopic placement of continuous ambulatory peritoneal dialysis (CAPD) catheter with novel technique of extraperitoneal tunnelling and cuff placement to prevent catheter migration.

Materials and methods:
A retrospective study was conducted in the department of urology from November 2017 to August 2018, Narayana hospital, Nellore. A total of 20 patients were taken into the study who had underwent laparoscopic CAPD catheter insertion.

Technique:
The standard 10mm camera port was placed. Another 5mm port was used for extraperitoneal tunnelling for CAPD catheter insertion. A Stiff metal rod was placed through left sided 5 mm port and port was removed. CAPD catheter was loaded over the metal rod and inner cuff was positioned in the extraperitoneal space.

**Results:**

All patients tolerated the procedure well. At 6 months follow up there was no incidence of catheter migration. All patients were discharged and allowed PD on POD 3 without any incidence of pericatheter leak.

**Conclusion:**

This technique of cuff positioning at the extraperitoneal space below the muscle prevents catheter migration.

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JR2. NEUTROPHIL-TO-LYMPHOCYTE RATIO: IS IT AN INDICATOR OF SPONTANEOUS PASSAGE OF URETERAL STONES.

DVSRK Prasad, Nitesh Kumar, Karthik M, Sunil Palve, Sanath T

Osmania medical college, Hyderabad

**Purpose:**

Conservative management of ureteral stones is affected by many factors of which Location and the size of stones are most important. Inflammation around the stone has been identifies as an important variable related to spontaneous passage of stone (SPS). Our aim was to investigate the role of neutrophil-to-lymphocyte ratio (NLR) for SPS.

**Materials and Methods:**
A prospective study was performed on 74 patients who attended urology outpatient clinic and emergency department between December 2017 and July 2018. Non-contrast-enhanced computed tomography (NCCT) was done in all patients for confirmation of ureteral stones. History, physical examinations and needed blood investigations, plain x-rays were done in all patients. SPS was confirmed by either patient noticing stone passing during urination or by NCCT done 3 weeks after the first stone episode. XLSTAT was used to analyze the data.

**Results:**

SPS was observed in 56 (77.7%) of patients out of 74 enrolled in the study. SPS rates within 3 weeks according to stone size were 60.4% (5-10 mm) and 85.6% (≤5 mm). NLR (<2.4) (odds ratio (OR), 8.96; p: 0.002), smaller stone size (≤5 mm) (OR: 9.28; p: 0.001) and lower stone location (OR: 10.86; p: 0.001) were independent predictors of SPS.

**Conclusion:**

A low NLR (< 2.4) may be a predictor of SPS for ureteral stones <1.0 cm size and ureteral inflammation is independent factor in SPS. So, early intervention may be considered in patients with high NLR (≥2.4).

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**JR3. ROBOTIC ASSISTED LAPAROSCOPIC REPAIR OF VESICO VAGINAL FISTULA: OUR EXPERIENCE AT A TERTIARY CARE CENTRE**

Mohsin Quadri, Arun Kumar Balakrishnan, Ramesh K, Ragavan N, Deepak Raghavan, Nitesh Jain.

Apollo Main Hospitals, Chennai, Tamil Nadu, India.

**Objective**

Vesico vaginal fistula (VVF) are rare, but when they are present they are devastating to women, causing distress due to persistent leakage of urine. Most VVF are the result of pelvic surgeries, where in 90% occur post hysterectomy. Our objective is to describe the surgical technique and outcomes with robot-assisted laparoscopic repair of VVF in 7 patients.

**Methods**
From July 2016 to July 2017, a total of 7 patients with VVF underwent robot-assisted laparoscopic VVF repair. The principles of VVF repair were followed. The fistula tract was excised. The vaginal defect and the cystotomy were closed, omental interposition done between the bladder and vaginal suture lines. Perioperative patient characteristics, complications, operative data, and follow-up results were retrospectively reviewed.

Results

All 7 patients developed VVF as a result of previous elective hysterectomies for benign indications out of which 2 were recurrent VVF’s. Mean operative time was 218 minutes (range, 150-330 minutes). Longer operative times were caused by concomitant surgeries (2 ureteric re implantations). Median length of stay in hospital was 3 days (range, 3-6 days). There were no intraoperative and significant postoperative complications. All patients were cured and were without VVF recurrence at a median follow-up close to 1 year.

Conclusion

Robot-assisted laparoscopic VVF repair is an effective approach to manage VVF even in complex fistulas and in recurrent cases. It is anticipated that an increasing number of VVF repairs will be undertaken with robotic assisted laparoscopic approach in offering more patients who need VVF repair at the advantage of minimally invasive surgery.

JR4. BLADDER PARAGANGLIOMA MASQUERADING AS UROTHELIAL CARCINOMA: A REPORT OF FIVE CASES AND REVIEW OF LITERATURE

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ABSTRACT

Introduction and objective

Paragangliomas are rare in urinary bladder. Till date, 200 cases have been reported in English literature. They arise from nests of paraganglionic cells that migrate along with sympathetic ganglia. Sometimes, paraganglioma mimics urothelial carcinoma clinically, but their treatment and prognosis varies. We are
reporting these cases in view of its rarity and importance of having clinical suspicion.

**Methods**

This is a retrospective study from 2011 to 2018 at Sri Venkateswara Institute of Medical Sciences that includes all patients diagnosed with paraganglioma, post transurethral resection of bladder tumour (TURBT).

**Results**

Five, out of 380 patients undergoing TURBT, were diagnosed with bladder paraganglioma. Male to female ratio was 3:2. The age ranged between 30 to 71 years. Painless hematuria (60%) being the most common presenting symptom, followed by suprapubic pain and irritative lower urinary tract symptoms. After histopathological examination, three patients underwent partial cystectomy and one patient underwent radical cystectomy. Average follow up period was 27 months.

**Conclusion**

Bladder paraganglioma is an extremely rare tumor, which can resemble urothelial carcinoma clinically and histomorphologically. Yellow, submucosal, highly vascular tumor on cystoscopy and rise in blood pressure on tumor manipulation should raise the suspicion of bladder paraganglioma. Surgery is the mainstay of treatment.

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**JR5. “ROLE OF TUNICA VAGINALIS FLAP AS SECOND LAYER COVER IN HYPOSPADIAS SURGERY”**

Dr. Sandeep Maheswara Reddy Kallam, Dr. Prakasa Rao Busam, Dr. Prabhakara Rao Medavankala

Guntur Medical College & Government General Hospital, Guntur, Andhra Pradesh, India.
Introduction & Objectives:

Hypospadias is a common congenital defect of male external genitalia. Goal of Hypospadias surgery is two-fold: A) To achieve a penis shape that is free of curvature so as to be adequate for sexual function and B) A glanular urethral meatus that allows voiding with a flow while standing. Objectives of this study were 1) To describe the clinical characteristics of hypospadias in study patients with regard to site of external urethral meatus. 2) To assess the outcomes of hypospadias surgery (Snodgrass with Tunica vaginalis flap as second layer) on follow up visits at 1 week, 1month, 3months and 6 months with regards to wound infection, skin loss, fistula formation and total failure.

Methods:

This was a prospective observational study conducted over a period of 2 years among 50 patients who were diagnosed with various forms of Hypospadias. All the patients who undergo Hypospadias surgery with tunica vaginalis flap cover are taken in to study. A note was made on the position of the meatus preoperatively and whether chordee was deemed to exist at that stage. All selected patients were operated by Tubularized Incised Plate (TIP) (Snodgrass) Urethroplasty with second layer coverage of the neourethra by tunica vaginalis flap according to the following operative technique and their postop follow up is done for a period to maximum 6 months and the results are studied. The study group characteristics like age group, anatomical details i.e. position of external urethral meatus, associated chordee, associated congenital anomalies, and average length of stay will be studied, rate of complications in the postop period, any association between the developments of complications with respect to the position of meatus will also be studied.

Results:

Out of 50 patients, a total of five different complications were observed in the span of 6 months of follow up. Wound infection (5%) is the most common complication in the initial first week of follow up. Fistula accounted for 6%.

Conclusion:

Results from this study indicate the excellent clinical outcomes with TIP procedure with TV Flap as 2nd layer in management of Hypospadias with acceptable complications rate of 6% fistula rate and overall success rate of 94%.
SAFETY AND Efficacy OF PCNL FOR MANagemENT OF stagHORN CALCULI IN A TERTIARY CARE CENTER

Dr. Raja Sekhar Guddeti¹, Prof. Arun Chawla²

1. Resident in Urology, KMC Manipal; 2. Professor and HOD Urology, KMC Manipal.

Introduction:

Percutaneous nephrolithotomy (PCNL) for staghorn calculi is one of the more challenging endourologic procedures because it is difficult to remove all of the stones and also associated with complications. The purpose of this study was to evaluate safety and efficacy of PCNL in staghorn patients in terms of stone-free rates and complication rates in our institute.

Patients and Methods:

105 patients underwent PCNL for staghorn renal stone disease at our institution from January 2016 to August 2018. Data analysis included procedure time, length of hospital stay, number of access tracts, transfusion rates, other early and late complications, and stone-free status.

Results:

Mean patient age was 48.6 years (range 16–82 yrs). The average procedure time was 64 minutes. Twelve percent of the cases needed multiple access tracts, with the lower calyx being the most commonly used in 51.5%, followed by the upper calyx in 47.3% and the middle calix in 12.6%. Various intracorporeal lithotriptors were used, including ultrasound, pneumatic, and holmium:yttrium-aluminium-garnet laser. The transfusion rate among this group was 9% while 2.1% patients underwent renal artery embolization. Stone-free rates at 1 month follow-up was 78.9%.

Conclusion:

PCNL is a safe and effective procedure in the management of staghorn calculi, with outcomes similar to those reported for percutaneous management of smaller
volume nonstaghorn stones. Accurate tract selection and placement as well as possession of the full array of endourologic equipment are essential to achieving an excellent outcome.

JR7. INCIDENCE OF URETHRAL OBSTRUCTION FOLLOWING BIPOLAR TRANSURETHRAL RESECTION OF PROSTATE (B-TURP)- A SINGLE CENTRE EXPERIENCE

Presenting Author : Dr. Gaurav Sharma

Co-Authors : Mallikarjuna C., K. Purnachandra Reddy, Ghous S.M., Bendigeri M.T., Ragoori D.R., Bhavatej E.

Institute : Asian Institute of Nephrology and Urology, Hyderabad, India

Abstract

Introduction:

Transurethral resection of prostate (TURP) is the gold standard treatment for benign prostatic hyperplasia (BPH). One of the major concern with transurethral resection of prostate is the development of urethral obstruction leading to obstructive voiding symptoms. Urethral obstruction may be due to urethral strictures or bladder neck contracture. Incidence of urethral strictures varies from 2.2% to 9.8% in the literature whereas that of bladder neck contractures varies from 0.3% to 9.2%.

Objectives:

To analyze the incidence of urethral obstruction (urethral stricture and bladder neck contracture) following B-TURP.

Material and Methods:
A retrospective analysis of patients with symptomatic BPH who underwent B-TURP at our institute from September 2015 to February 2018 with a minimum follow-up of 6 months were included in the study. Hospital records were analyzed for postoperative follow up of these patients. Patients who had previous history of urethral strictures and transurethral instrumentation, histopathology proven carcinoma prostate, hypotonic bladders and patients who lost follow-up were excluded from the study. Urethral obstruction following B-TURP in follow-up was defined as: 1) patients with obstructive voiding symptoms, 2) poor flow on uroflowmetry and 3) failed urethral calibration. Patients with features suggestive of urethral obstruction were further evaluated with retrograde urethrogram (RGU) and/or cystoscopy to identify the location of urethral obstruction.

Results:

A total of 1355 patients underwent B-TURP for symptomatic BPH from September 2015 to February 2018 at our institute. Out of which, only 825 patients were enrolled in the study. Amongst these, 116 (14%) cases developed features suggestive of urethral obstruction and required evaluation in the form of urethral calibration. 39 (4.72%) out of 116 were found to have urethral stricture and 10 (1.2%) had bladder neck contracture. Among those with urethral strictures, 13 (1.57%) cases had sub-meatatal stenosis. Rest of the 67 patients did not have any urethral obstruction.

Conclusion:

Urethral obstruction following TURP is a known long term complication. Incidence of urethral stricture and bladder neck contractures post B-TURP in our study was 4.72% and 1.2% respectively.
SESSION 2

JR8. SAFETY AND EFFICACY OF SUPERIOR CALYCEAL ACCESS VERSUS INFERIOR CALYCEAL ACCESS FOR PELVIC AND LOWER CALYCEAL STONES – PROSPECTIVE OBSERVATIONAL STUDY

Dr. Amaresh Mohan¹, Prof. Arun Chawla²

¹. Resident in Urology, KMC Manipal, ². Professor and HOD, Urology, KMC Manipal

Introduction:

Percutaneous nephrolithotomy (PCNL) is the treatment of choice for large renal stones. The success of PCNL is highly related to optimal renal access. Two approaches are commonly employed to gain access to the stones located in the pelvis and lower calyx which consist of superior calyx approach or inferior calyx approach. Superior calyceal puncture being more difficult and more demanding have relatively few studies presented.

Aims and Objectives:

This prospective study was carried out to evaluate the safety and efficacy of superior calyceal versus inferior calyceal puncture for the removal of pelvic and lower calyceal stones.

Materials and Methods:

A total of 126 patients underwent PCNL for stones in pelvis and lower calyx were studied. Sixty three of them underwent inferior calyceal, while 63 underwent superior calyceal puncture. The two approaches were compared in terms of stone clearance rate, operative duration, intraoperative blood loss and rate of postoperative complications (pulmonary, bleeding, fever and sepsis).

Results:

In our study, the stone clearance rate was 65.54% for those in the inferior, 78.95% for those in the superior calyceal access group. Thoracic complications (hydrothorax) occurred to 1 patient in superior calyceal access group. Bleeding requiring blood transfusion happened to 8 patients in inferior calyceal access and 1 in superior calyceal group.

Conclusion:
We conclude that superior calyceal puncture is a feasible option minimizing lung/pleural rupture and gives a better clearance rate. We suggest that there should not be any hesitation for superior calyceal puncture in indicated patients.

9. AUGMENTATION CYSTOPLASTY: OUR EXPERIENCE


Narayan medical college, Nellore

INTRODUCTION AND OBJECTIVE

Augmentation cystoplasty has traditionally been used in the management of small capacity, poorly compliant, or refractory overactive bladder. In properly selected patients, augmentation cystoplasty is an excellent procedure that provides a safe and effective way of improving urinary storage and preserve renal function.

The primary objective of our study is to analyse the results of augmentation cystoplasty.

MATERIALS AND METHODS

18 patients with small capacity bladder and bladder dysfunction who underwent augmentation cystoplasty in our institution from October 2017 to June 2018 were studied. All the patients were followed up one month after surgery and every 3 months thereafter with complete metabolic profile and renal function tests.

RESULTS

Out of 18 patients, 11 were males and 7 were females. Total 10 patients had serum creatinine more than 1.4mg/dl (upper limit of normal range of our laboratory) at the time of presentation. The etiopathogenesis included GUTB in 5 patients, neurogenic bladder in 4 patients, poor complaint bladder in 6 patients, bladder extrophy in 2 patients and traumatic bladder injury in 1 patient. All these patients underwent Augmentation cystoplasty with ureteric reimplantation (except one patient who underwent augmentation cystoplasty alone). 9 patients underwent MONTI, 1 patient underwent Mitrafanoff and 3 patients underwent MACE procedures concomitantly along with augmentation cystoplasty depending on their presentation. Among 10 patients with elevated creatinine, on follow up renal
function improved in 8 patients, 1 patient renal function is stabilised at the preoperative level and in 1 patient the renal function deteriorated (because of poor patient compliance to CIC). 1 patient died of septic shock because delayed bowel leak presenting 1 month after surgery.

CONCLUSION

Pre-operative thorough counselling of the patients regarding the procedure, complications, post-operative care and follow up protocol plays an important role in the overall outcomes of these major surgeries. Ureteric reimplantation in thickened bladders helps in improving the renal function.

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**JR10. PERCUTANEOUS NEPHROLITHOTOMY IN ANOMALOUS KIDNEYS - 3 YEARS SINGLE INSTITUTION EXPERIENCE**

Sharma yagneshwar, kumar anil

Sri Venkateswara institute of medical sciences, Tirupati, Andhra Pradesh, India

**Introduction And Objective**

Anomalous kidneys such as horseshoe kidney, crossed ectopic kidney, simple ectopic kidney, pelvic ectopic kidney, kidney with duplex system, and malrotated kidney are frequently associated with stone disease. Percutaneous nephrolithotomy (PCNL) is difficult in these patients because of abnormal orientation of kidney. This study aimed to evaluate the safety and efficacy of percutaneous nephrolithotomy in anomalous kidneys.

**Methods**

Between June 2015–June 2018, 20 patients underwent PCNL for stone removal in anomalous kidneys. Stone characteristics, number of puncture, type of calyceal puncture, need of relook procedures, mean hemoglobin drop, mean operative time complications, mean hospital stay, stone free rate, and auxiliary procedure were analyzed.

**Results**

Totally 21 sessions of PCNL was done in 20 patients including one patient of horseshoe kidney who had bilateral stone disease. Mean age, duration of symptoms, stone size, and hospital stay was 24.6 ± 16.6 years, 1.18 ± 0.6 years,
3.40 ± 1.16, and 4.1 ± 1.6 days, respectively. One Patient underwent relook procedure

**Conclusion**

PCNL in anomalous kidney is safe and effective procedure similar but requires careful preoperative planning and intra- and post-operative vigilance.

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**JR11..A STUDY OF VARIOUS FACTORS INFLUENCING POSTOPERATIVE COMPLICATIONS IN PCNL.**

Authors: rahul nair, rahul devraj, vidyasagar s, ramchandriah, raghuveer p, charan gv, ram reddy ch.

Department of Urology – NIMS Hyderabad

**Introduction**

Percutaneous nephrolithotomy (PCNL) has been one of the most important procedures for handling stones in the upper urinary tract. Estimated life time prevalence of the disease is 1-15%, Males are affected two to three times more often than females. Advances in PCNL over the past several decades has not only revolutionized the treatment of renal stones but also has facilitated the ease with which stones are removed. Since its first report in 1976, PCNL has become standard of treatment for staghorn calculi, treatment failures of ESWL and difficult lower pole calculi. PCNL is cost effective as it requires a shorter hospital stay and allows early return to work. The technique has a steep learning curve in traditional sense which implies large number of cases performed to master the technique. PCNL has certain complications specific to it. These include hemorrhage requiring transfusion, fever, sepsis, extravasation, pleural injury and colonic injury which can cause serious morbidity and mortality. The true incidence of complications at different centers are difficult to compare due to lack of standardization. The present study aims at studying these complications using Clavien or modified Clavien system and analyse the factors responsible for these complications.

**Method:**

A total of 125 patients who underwent PCNL for renal calculc disease in a span of 8 months were incorporated into this study. Details were obtained from the patient records which includes age, sex, intra venous urogram, CT urogram, DTPA renogram, urine culture and sensitivity, total leucocyte count, serum creatinine, were collected from each individual records. The post operative complications are noted and the factors predicting these postoperative
complications will be statistically analysed. The various post operative complications that were analysed were fever, sepsis, hemorrhage requiring blood transfusion, pleural injury and colonic injury. The various factors that were analysed were preoperative (presence of diabetes mellitus, stone size, number of calculus, urine culture and sensitivity and pyelocaliectasis) and intraoperative (pelvic urine culture, stone culture, intraoperative bleeding, number of tracts, size of tracts, intraoperative time and supracostal tracts).

**Results:**

125 patients were included in the sample study. Mean age was 42 years. 65 male and 60 female patients. 28 were known diabetics. Average stone size was 3.9672 cms. 99 patients had single calculus, remaining had more than 1 calculus. 46 patients showed preoperative positive urine culture growth. 30 patients had pyocelectasis. 15 patients had intraoperative bleeding. 101 patients single tract puncture, rest had >1 tracts. The average operative time was 45.72 minutes. 8 patients had supracostal punctures. 10 patients had hemorrhagic complications out of which 9 required post operative blood transfusion and 1 patient required angioembolisation. 26 patients had post operative fever and 2 of them developed frank sepsis. 3 patients developed pleural injury and were treated conservatively. No incidence of visceral injuries were noted.

**Conclusion:**

Based on our study the various factors which had a direct impact on post operative complications in PCNL were stone size, no of calculus, presence of DM, positive urine culture and sensitivity, prescence of pyocalyectasis, intraoperative bleed, number of tracts, intraoperative time and supracostal punctures. Pelvic urine culture and stone culture had no predictive value.

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**JR12. A RETROSPECTIVE STUDY AND FOLLOW UP ON RENAL CANCER – A SINGLE CENTER STUDY**

**Authors:** kousik A, rahul devraj, vidyasagar s, ramchandriah, raghuveer p, charan gv, ram reddy ch

**NIMS, Hyderabad**

**Aim:**

To review the clinicopathological factors, treatment and follow up of renal cancers at our hospital.

**Materials and methods:**
A retrospective review of all renal cancers referred to Urology department, NIMS from January 2014 to August 2018. Standard follow up schedule was given to all patients based on the disease staging.

**Results:**

102 cases of renal malignancies were identified. Of the 102 cases 62 were males and 40 were females. 98 cases underwent surgery and remaining four were referred to medical oncology. Of the 4 cases two were clear cell carcinoma and received Sunitinib and other two were Non Hodgkins Lymphoma and chemotherapy was initiated. The standard treatment was radical nephrectomy and partial nephrectomy. Of the 98 cases 84(86%) underwent radical nephrectomy and 14(14%) underwent partial nephrectomy. Renal vein thrombus was present in 8 cases (7.8%) and thrombus extension into Right atrium in one case. Thrombectomy was done for these cases. 2 patients expired in the post operative period. One case was reported as Extra intestinal gastrointestinal stromal tumor and one was reported as Ewings sarcoma and received appropriate adjuvant therapy.

**Conclusions:**

The standard management of renal cell cancer is radical nephrectomy and adjuvant therapy was initiated according to histological variant. Close follow up is essential part of management of renal cancers.

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**JR13.COMPLICATIONS OF RENAL TRANSPLANTATION AND IT'S MANAGEMENT : AN INSTITUTIONAL EXPERIENCE**

**Dr shanti Vardhan, dr fraz, dr vinay, dr arabind, dr neil, dr umamaheswar rao, dr gopichand**

**Kims , Secunderabad**

**Introduction:**

Renal transplant is an effective treatment offered to individuals with chronic kidney disease and end stage renal disease. It has proved to be more effective in prolonging the survival of the affected patients than other methods such as peritoneal and haemodialysis. But as an surgical procedure renal transplant is also not devoid of complications.

**Materials and methods:**
We report the patients who underwent renal transplant in our institute and had complications which vary from vascular, infective, reflux, immunological and so on. All the patients with complications managed effectively in our institute were reported in this case series.

**Conclusion:**

Though renal transplant has many complications a close vigilance, effective use of investigative modalities, and prompt surgical correction if necessary, a multimodal approach with neurologist, helps to successfully tackle these complications.

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**JR14. A RETROSPECTIVE ANALYSIS OF OUTCOME OF LIVE DONOR RENAL TRANSPLANTATION CASES DONE IN OUR INSTITUTE.**

**AUTHOR:** Jitendra k barad, Rahul Devraj, Vidyasagar S, Ramachandraiah, Raghuveer P, Charan GV, Ram reddy Ch.

**INSTITUTION:** Nizam’s Institute of Medical Sciences, Hyderabad, Telangana, India.

**Introduction And Objectives:**

Renal transplantation is the treatment of choice for the patients with End Stage Renal disease (ESRD). Due to advance in surgical techniques and immunosuppression it’s becoming more popular day by day. in our institute renal transplantation started in June 1989 and around 1200 cases done till now. We want to find out the outcome statistics in our patients and to compare the results with other groups.

**Method:**

Retrospectively data collected from the transplant record for all the patients who underwent live donor renal transplantation between January-2013 to December-2017 at nims, Hyderabad. Data’s like donor and recipient age and sex distribution, graft function, post op complication, 1-year graft survival and 1-year mortality studied.

**Observation:**
There were 482 patients; who underwent renal transplantation during the study period, out of which 356 are live transplant cases (73.8%). Mean age of recipient was 32.4 years, predominantly males (81.5%). Mean age of the donor 44.6 years, with female predominance (82.6%). In 91.3% cases immediate graft function was present. DGF (delayed graft function which required dialysis) was noted in 2.9%, SGF (slow graft function but no need of dialysis) was noted in 5.8%. Biopsy done in those with DGF/SGF; shows acute tubular necrosis (ATN) in 69.6%, acute interstitial nephritis (AIN) in 21.3%, thrombotic microangiopathy (TMA) in 9.1% of all 33 cases. 2 patients (0.05%) died within 2 weeks after surgery, one due to CVA and another due to encephalopathy. Graft nephrectomy was done in 3 cases (0.84%). Perinephric collection was noted in 3.08%, wound infection in 1.7% and urinoma in 0.842%. There were no complications like arterial or venous thrombosis, anastomotic leaks and re-explorations. 96.1% cases survived up to 1 year. 14 cases (3.93%) died within 1 year most due to infection. In patients who survived, graft survival rate was 99.2%.

**Conclusion:**

Live renal transplantation is a viable option for patients with ESRD. Surgical complications are minimal and graft survival rates is good in our patients and comparable to studies done in other institutes.

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**SESSION 3**

**JR15. BLEEDING DURING PERCUTANEOUS NEPHROLITHOTOMY - VARIOUS AFFECTING FACTORS**

**DR Sunil palve Dr.DVSRK Prasad, , sanath T, Nitesh kumar, Karthik M**

Osmania medical college, hyderabad.

**Purpose:**

percutaneous nephrolithotomy (PCNL), is endouroogical procedure. There are many variable factors affecting bleeding during this procedure, our aim is to investigate these variable factors.
**Materials and Methods:**

A prospective study was performed on 105 patients operated for percutaneous nephrolithotomy (PCNL) in urology operation theatre in Osmania general hospital between September 2017 to August 2018. The effect of patient and stone-related factors, including age, sex, hypertension, and diabetes, serum creatinine level, history of ipsilateral renal procedures, stone surface area and type, degree of hydronephrosis, preoperative hemoglobin level; operative factors, such as the calyx of puncture, number of accesses, operative time; and intraoperative complications, such as pelvicalyceal system perforation on bleeding (described as decrease in hemoglobin level and need for blood transfusion), were investigated.

**Results:**

A 94% success rate was achieved after one session PCNL. The overall blood transfusion rate was 8.5%. The number of accesses, stone type, diabetes, preoperative hemoglobin level, and operative time were the most important factors for blood transfusion requirement. In the receiver operating characteristic curve, the best cutoff point of operative time was 1 hr and 5 minutes for the blood transfusion requirement.

**Conclusion:**

Based on the results observed, multiple access tracts, staghorn calculi, presence of diabetes, and prolonged operative time, observed to be significantly increasing blood loss during PCNL.

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**JR16. TWO CASES OF RENAL CELL CARCINOMA WITH LEVEL III RETRO HEPATIC EXTENSION OF TUMOUR THROMBUS**

**DR RAHUL.K. DR A.V.RAVI KUMAR, DR CHANDRASHEKAR, DR DEEPAK BACHU, DR SARIKA H PANDAY, DR HARISH, DR SURENDERA REDDY BANKA,**

Maxcure hospital, Hyderabad

A unique feature of Renal Cell Carcinoma is its predilection to involve venous structures.
Tumour can grow along the renal vein into the Inferior Vena Cava up to Right Atrium in 410% of cases. Although this worsens the prognosis, but if the tumour has not spread to the surrounding lymph nodes and has not metastasized, the tumour can still be controlled surgically. With the help of Surgical Gastroenterology and Cardio Thorasic departments, we were able to successfully tackle these tumours.

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JR17.RETROPERITONEAL FIBROSIS MANAGED SUCCESSFULLY BY MINIMAL INVASIVE SURGERY- CASE SERIES
Author : Dr. Manoj kumar sahu

Co-Authors : Mallikarjuna C., K. Purnachandra Reddy, Ghouse S.M., Bendigeri M.T., Ragoori D.R., Bhavatej E.

Institute : Asian Institute of Nephrology and Urology, Hyderabad, India.

Abstract

Introduction:

Retroperitoneal fibrosis (RPF) is a rare disease characterized by fibroblastic proliferation, collagen deposition and infiltration of inflammatory cell in the retroperitoneum that frequently causes ureteral obstruction. The idiopathic form accounts for more than two-thirds of all cases of RPF, with the remainder being secondary to different causes, such as tumours, infections, radiotherapy and drugs.

Objective:

To report our experience in the management of Retoperitoneal fibrosis(RPF) by minimal invasive surgery.

Material and Methods:

We retrospectively analyzed case records of patients of RPF who underwent minimal invasive surgery (ureterolysis and omental wrapping) from January 2016
to June 2018 at our institute. Retroperitoneal fibrosis was diagnosed by operative biopsy and imaging (retrograde pyelography and computed tomography or Magnetic resonance imaging). Perioperative parameters, surgical details and postoperative follow-up was recorded. Success was defined by improvement in symptoms, improvement in renal parameters and no signs of obstruction on imaging.

**Result**
Out of 10 patients, 9 were male and one female. Mean age was 48.3 years (range, 27 to 73 years). All patients presented with back pain and had hydroureteronephrosis on ultrasound or computed tomography, eight patients were prestoned, two patients were on prednisolone. One patient presented with AKI and serum creatinine did not decrease after bilateral stenting, so bilateral percutaneous nephrostomy done. One patient diagnosed to have left pelvi-ureteric junction and retroperitoneal fibrosis on right side, with bladder outlet obstruction. On retrograde pyelography, all patients showed hydronephrosis with smooth narrowing and medialization of the ureter. All patient underwent ureterolysis and omental wrapping, two patients on left side and two on right side and six patient underwent bilateral ureterolysis. One patient underwent Heineke-Mikulicz stricturoplasty due to dense narrowing. Intraoperative and postoperative period were uneventful. Biopsy report showed chronic inflammation and fibrosis in nine patients, one report showed spindle cell carcinoma. All Patients discharged on 3rd to 4th post op day, and stent removal done after 4 weeks. With a mean follow-up of 6 months, all patients were asymptomatic and had no signs of obstruction on imaging and normal creatinine level.

**Conclusion**
Retroperitoneal fibrosis is an uncommon entity, RPF should be considered in the presence of unexplained obstructive uropathy with soft-tissue mass surrounding the retroperitoneal structures. The initial goal of management is to relieve the obstruction and preserve renal function followed by surgical management. Long-term assessment is mandatory as recurrences have been reported even after 10 years.
From The depart.of Urology & Renal Transplantation, KIMS, Narketpally.

Authors: Dr. Dimple Kumar, M.Ch-PG

Abstract:
Excision and end-to-end anastomosis (EPA) has been the preferred urethroplasty technique for short bulbar strictures and is associated with an excellent functional outcome. Driven by concerns over the potential morbidity associated with dividing the urethra, therefore compromising spongiosal blood flow, as well as spongiofibrosis being superficial in the majority of non-traumatic bulbar strictures, the non-transecting technique for bulbar urethroplasty has been developed with the aim of achieving the same success as EPA without the morbidity associated with transection.

Our experience with the first 2 cases of this technique is presented. Non-transecting excision of spongiofibrosis with preservation of well vascularised underlying spongiosum provides an excellent alternative to dividing the urethra during urethroplasty for short non-traumatic proximal bulbar strictures.

Introduction:
The optimal management of bulbar urethral strictures continues to generate much debate within the reconstructive urological community; endoscopic intervention (dilatation or urethrotomy) vs. urethroplasty, flap vs. graft, dorsal or ventral augmentation, just to mention a few of the controversial issues commonly discussed. Most recently the question of whether to transect the bulbar urethra or not in non-traumatic strictures has been raised.

Materials & Methods:

Case 1. A 16 year boy developed short bulbar stricture following fulguration of anterior urethral valves at the age of 8. He underwent VIU twice before taking up for non-transecting bulbar Urethroplasty. He completed 8 months follow up and doing well with good flow rate.

Case 2. A 23 year old man presented with obstructive urinary symptoms of 1 year duration. He was a known case of stricture urethra and underwent VIU 18
The RGU showed short segment stricture of bulbar urethra for which he underwent non-transecting urethroplasty.

**Technique:**

The bulbar urethra is exposed at the stricture site through a perineal incision. The stricture is exposed either by dorsal/ventral urethrotomy. The fibrous element of the stricture is excised all around without transecting urethra and the normal cut end mucosal edges are sutured. The urethrotomy is closed transversely with interrupted absorbable sutures leaving a 14F foley catheter indwelling.

**Results:**

Both of the patients are doing well. However, they need long term follow up. There were no post of complications.

**Discussion:**

The decision to perform transection vs. non-transection of the corpus spongiosum during urethroplasty was based on stricture characteristics (length, location, lumen, and cause). Primary non-transecting bulbar urethroplasty long-term success rates are similar to transecting urethroplasty.

**Conclusion:**

Non-Transecting urethroplasty is a simple alternative procedure in selected cases of short segment bulbar strictures.

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**JR19. AN INITIAL EXPERIENCE WITH SUPER PERCUTANEOUS NEPHROLITHOTOMY. A CRITICAL ANALYSIS OF FIRST TEN CASES.**

**DR Fraz, Dr Arabinda Panda Dr Vinay R**

**KIMS, HYDERABAD**

**Introduction:** Nephrolithiasis is one of the most common conditions encountered in Urology. Depending upon the size, compositions, numbers, site and presence of infection, various surgical interventions have been in practice. With the advent of endoscopic techniques for stone removal, today PCNL has became the most frequently done surgery. Evolution in PCNL techniques gave rise to newer methods like micro perc, mini perc, UMP. Super perc is the newer weapon in d
arsenal of Urologists which involves use of negative suction of better stone clearance and decreased surgery time.

**Background:**

Super PERC is the method of using suction cannula and suction master attachment with suction unit with the super PERC sheath on mini pcnl equipments for better surgical outcomes.

**Objective:**

To evaluate and assess Super Perc on preoperative, operative and post operative variables and ease of acceptance of the newer technique.

**Methods:**

Ten cases having renal calculi between 1-2 cms with anesthesia fitness posted for Super PERC Technique from April 2018 to August 2018 were enrolled. Each case was reviewed on pre operative variables like numbers, location and size of calculi.

Operative factors considered were Number of puncture sites, calyces access, time for stone clearance and surgeons ease in using the equipments. Post operatively, days of stay, need of pcn tube placement , day of pcn tube removal, Haematuria, need of i.v pain killers were discussed.

**Results:**

Ten cases were reviewed. Out of which, six males and four were female. Calculi size ranging from 1.2 to 2 cms with 6 in right and 4 in left kidney with 3 cases were having single calculus and 7 were having multiple calculi. Calculi were in single calyx in 4 cases, in 5 cases in 2 calyces and in one case calculi were in all the 3 calyces.

Operatively, on average 1.4 puncture taken for renal access for calculi and total stone clearance time was 45.8 minutes which was lesser than other methods of pcnl. In all cases, 14 Fr ryles tube was inserted as pcn tube. Super perc attachments were easy to attach to the pcnl set and required no special skill set. In all the cases complete stone clearance achieved. Post operative, pcn tube was removed on post operative day 1 and patient discharged the same day. No post gross haematuria observed with minimal need of post operative iv analgesics requirement. In follow up, complete stone clearance was reconfirmed.
Super PERC technique simplified stone clearance and reduced stone migration rate with reduced post operative analgesia requirement and reduced incidence of haematuria.

**Conclusion:**

Super PERC is simplified easy modification of mini pcnl which reduces stone clearance time, increases stone clearance and with decreased post operative pain and haematuria. Its use should be promoted.

**JR20. BENIGN RENAL MASSES MASQUERADING AS RENAL CELL CARCINOMA OF KIDNEY.**

Tushar Sharma, N Anil Kumar, A Tyagi, S V Chaitanya, A Jaibabu

SVIMS, TIRUPATHI

**ABSTRACT**

**Objective:**

To assess the incidence of benign renal lesions in partial/ radical nephrectomy surgical specimens at our institution and assess the predictive factors for the same.

**Methods:**

This is a retrospective study which included all patients who underwent radical/partial nephrectomy for renal cell carcinoma diagnosed by contrast enhanced computed tomography between January 2015- August 2018. Patients records were reviewed, and final histopathology reports were noted. Patients were then divided into benign and malignant groups and statistical analysis was done for age, sex, laterality, smoking, size on imaging, multifocality between the two groups.

**Results:**
Among the 64 cases, 12 (18.75%) were benign. The 12 benign cases included 5 cases of oncocyotma, 3 cases of angiomyolipoma, one case each of mixed epithelial stromal tumor, leiomyoma, hydatid cyst and renal tuberculosis. On statistical analysis we found age (<50 years), female sex, smaller size lesion (less than 4 cm) were predictive of benign lesions.

**Conclusions:**

Incidence of benign lesions in our series was 18.75% with age<50 years, female and smaller size being positive predictive factors.

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**JR21. DISTAL HYPOSPADIAS: A COMPARISON OF MATHIEU FLIP FLAP VS SNODGRAS TIP**

Dr. Khizar Raoof, Dr. M. A. Majid Adil, Dr. Avais Altaf, Dr. Raghavendra Prasad.

Department of urology, Deccan college of medical sciences, hyderabad.

**INTRODUCTION:** Hypospadias is the commonest external congenital abnormality encountered by surgeons, the repair of distal hypospadias is complex comprising flaps: local and rotational, single staged vs staged.

**PROCEDURES:** Repair has been revolutionized by Snodgras who proposed tubularised incised metatoplasty. Earlier Mathieu’s Flip Flap was considered an ideal repair for distal hypospadias.

**AIMS & OBJECTIVES:** To compare the Snodgras procedure with the Mathieu and combined Snodgras-Mathieu procedure.

**MATERIALS & METHODS:** From the year 1979 to 2012, all the cases studied were divided into 3 groups:

1. Group 1 : Mathieu flip flap repair
2. Group 2: Snodgras TIP repair

3. Group 3: Snodgras-Mathieu combined repair

Parameters studied: were age at operation, meatal stenosis, urethrocutaeneous fistula, urinary stream and glandular cosmesis. Random allocation was given. Under 1 year 11 patients were under group 1, 9 under group 2 and 13 under group 3. Between 1 to 5 yrs 21 in group 1, 25 in group 2 and 19 in group 3. Above 5 years 27 in group 1, 25 in group 2 and 27 in group 3, the procedure was random in groups of 9.

RESULTS: A total of 59 cases were operated in each group. Complications of meatal stenosis was least with group 1 & 3 and more with group 2, Urethrocutaeneous fistula occurrence was 7 out of 59 in group 1, 12 in group 2 and 9 in group 3. There was 1 case of sprayed stream and total wound dehiscence in group 2. Glandular cosmesis graded by parents was uniformly acceptable in all groups.

procedure which is a Snodgras tubularisation in collaboration with a Mathieu flip flap. Details of operative procedure will be shown.

JR22.HOME URODYNAMIC : A PROSPECTIVE VALIDATORY STUDY TO IDENTIFY PATIENTS AT HIGH RISK FOR RENAL DETERIORATION


Institution:Dept. Of Urology, Narayana Medical College, Nellore, Andhra Pradesh

Objective:

To validate the efficacy of home urodynamics to document pressure /volume to identify high risk patients.

Introduction:
Urodynamics is gold standard method to measure the bladder pressure/volumes in neurogenic bladder patients on CIC. Home urodynamics is a valuable cost efficient method to monitor bladder pressures at home. This will help us identify patients with high bladder pressures and intervene early to prevent upper tract deterioration. We present our early results of home UDS and validate its efficacy in identifying high risk patients.

**Methodology:**

20 patients with neurogenic bladder are enrolled. All patients with bladder dysfunction on CIC were included in the study. Prior complete neurological examination, UFR with PVR, urine C/S, Sr.creatinine, USG abdomen was done for all patients and subjected to UDS. Patients underwent urodynamics to record the initial pressure/volume and patient/caregiver was educated regarding home urodynamics to measure pressure/volume on a weekly basis and for 3 consecutive days before planned UDS. PVD result was collected from all patients before leak or scheduled drainage time and was compared with UDS. Pressures recorded in the PVD at largest CIC volume and mean pressure from all recorded data were collected. Mean volumes of cystometric capacity on UDS and PVD were measured and data are compared. UDS was done on 0,1,2,3 months and data collected are compared for further management.

**Results & Observations:**

Mean pressures recorded in PVD were most reliable to predict Pdet on UDS. Cystometric capacity was not correlating with UDS measurements. Patients are under regular follow up and tele-medicine has been used for reporting USG/PVD and to advice further management.

**Conclusions:**

Home UDS is an cost effective method to identify high risk patients with neurogenic bladder on follow up. We need more patients and longer follow up to validate this concept.

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**JR23 PREOPERATIVE VENOGRAM IN DIFFICULT VASCULAR ACCESS SURGERY**


Department Of Urology and Renal Transplantation, Narayana Medical College, Nellore, Andhra Pradesh
**Objective:**

The purpose of this study is to evaluate the impact of preoperative venography on the planning and outcome of haemodialysis AVF creation.

**Introduction:**

As the number and complexity of patients on dialysis increases, this presents an increasing challenge for vascular access. Successful renal access surgery requires both careful planning and technical skill. Venography offers direct imaging of both peripheral and central veins in the upper limb.

**Methods:**

This is a prospective analytical study comparing outcomes between patients operated for difficult vascular access. Between October 2017 - March 2018 venography was done at our institute prospectively for difficult vascular access cases. All patients who had prior 2 failed AVF surgeries were included in study, evaluated with Physical examination, Doppler imaging and Venography. We analysed venograms and compared the outcomes before and after venography based on historic control before venogram.

**Results:**

During the study period, preoperative venography was performed in 30 patients and 54 upper limbs. 6 patients (20%) did not receive an AVF as haemodialysis access. Compared to control group we had significant outcomes of patency (p = 0.036), reduced lymphoedema (p = 0.035) and high access of distal fistulae (p = 0.012) in our venogram patients.

**Conclusion:**

Venography is a useful investigation modality for venous mapping prior to difficult vascular access surgery along with preoperative Doppler imaging, resulting in an overall patency rate.
ASSOCIATION OF SQUAMOUS CELL CARCINOMA WITH NONFUNCTIONING KIDNEY DUE TO STONE DISEASE

Dr Yogesh Torkadi, Dr. Rahul Devraj, Dr. Vidyasagar, Dr. Ramachandriah, Dr Charan, Dr. Ram reddy
NIMS, Hyderabad, Telangana, India.

Introduction And Objectives

Primary carcinoma of renal pelvis account for 4-5% of all urothelial tumour. Among these squamous cell carcinoma accounts for 0.5-0.8% of all renal tumour. Squamous cell carcinoma (SCC) of the renal pelvis is a rare neoplasm and is usually associated with long standing renal stone disease. There is lack of definite clinical presentation and inconclusive imaging finding, this tumours are high grade, highly aggressive with poor prognosis. Histopathology report is hallmark for diagnosis.

Method

We have a sample size of 5 patient (3 male and 2 female), presenting complaints of all pts have a chronic history of renal stone disease with loin pain, with all pt have serum creatinine within normal limit, on NCCT KUB 3 patient have multiple calculi with hydronephrotic kidney, 1 patient have small size kidney with single calculi, 1 patient have single calculi with pyelonephritic changes and on renogram finding of all patients suggestive of nonfunctioning kidney.

Result

In our study mean age is 52 year, 3 male and 2 female, mean operative time-2hr, during postoperative period 3 patient have uneventful postoperative course, 1 patient have atrial fibrillation, 1 patient have a suture site infection, average hospital stay 4.5 days. Postoperative histopathology report confirmed presence of squamous cell carcinoma, 4 patient on regular follow up with no evidence of recurrence and 1 patient lost follow up.

Conclusion

Primary squamous cell carcinoma of kidney are rare aggressive tumour with poor prognosis. As this tumour associated with renal stone and Non functioning kidney, should be evaluated with newer imaging technology for early detection of tumour.
**JR25.** “RANDOMIZED CONTROLLED STUDY COMPARING TRANSURETHRAL RESECTION OF PROSTATE AND TRANSURETHRAL INCISION OF PROSTATE IN THE MANAGEMENT OF LOW VOLUME BENIGN PROSTATIC HYPERPLASIA.”

**AUTHORS:**

Dr. Sandeep Maheswara Reddy Kallam, Dr. Sridhar Parnandi, Dr. Prakasa Rao Busam

**INSTITUTE:**

Guntur Medical College & Government General Hospital, Guntur, Andhra Pradesh, India.

**Introduction & Objectives:**

Bladder outlet obstruction (BOO) in benign prostatic hyperplasia (BPH) is due to static and dynamic factors. In low volume BPH, prostatic smooth muscle tension plays a more important role than the prostatic hyperplasia as such. Transurethral incision of prostate (TUIP) relieves the outlet obstruction without resecting prostatic tissue and hence can be a viable alternative to transurethral resection of prostate (TURP) in these patients. This study was done to compare these two surgical techniques of low volume BPH.

**Methods:**

This was a randomized prospective study done from March 2016 to March 2018 at department of Urology of Government General Hospital, Guntur in 40 patients with lower urinary tract symptoms (LUTS) due to low volume BPH (Ultrasound prostatic volume of 20-40cc). The patients were randomized into two groups (TURP and TUIP groups) by computer generated randomization tables. Allocation to the groups was done by a sealed envelope technique which was opened on the day of surgery. 20 patients underwent conventional TURP and 20 underwent TUIP. Subjective and objective improvement post-surgery was compared using International Prostate Symptom Score (IPSS) questionnaire and uroflowmetry respectively. Intraoperative parameters between the two groups were compared.

**Results:**

Preoperative parameters like Age, IPSS, Prostate volume, Post void residual urine volume and peak urine flow rate (Qmax) were comparable between the groups. Intraoperative parameters like mean operative time, amount of irrigation fluid used and blood loss were significantly less in TUIP group than TURP group (p <0.001). Postoperative IPSS and Qmax improved significantly in both the groups with no significant difference among the two groups.
**Conclusion:**

TUIP is an effective method for the treatment of low volume BPH with equivalent results to that of TURP. TUIP has a reduced operative time, little intra operative haemorrhage and less irrigation fluid requirement than TURP. TUIP is a cost effective technique with an easy learning curve and can be safely applied for prostates of up to 40 grams with minimal complications and good short term results.

**Introduction:**

Adrenal gland hosts many tumors both benign and malignant. Being a source for various hormone production in the body these tumors have varied clinical presentation. This study is aimed to evaluate the clinicopathologic characteristics, treatment and follow up of patients with adrenal tumors in our hospital.

**Materials And Methods:**

The clinicopathologic characteristics and treatment of 20 patients with Adrenal tumors treated at our institution between September 2017 and August 2018 were retrospectively analyzed.

**Results:**

The study cohort comprised 20 patients. Out of them 6 were male and 14 were female patients. Median age at diagnosis is 37 years [range 15-70 years]. The median tumor size was 6.8 cm(range 1.3-16.0 cm). Out of 20, 11 are right sided tumors and 9 are left. Out of 20, 3 are Adenomas, 10-Pheochromocytomas, 2-Myelolipomas and 5-Adrenocortical carcinomas(ACC). Clinical presentation of these tumors varied diversely. Headache, palpitations, sweating, syncopal attacks present in 7 cases of pheochromocytoma out of 10. Torsades de pointes (polymorphic ventricular tachycardia) in 2 cases of pheochromocytoma. Conns syndrome in one case of adenoma.Cushing syndrome in one case of adenoma.
Hirsutism in 2 cases of ACC. 19 cases had adrenalectomy as the treatment and distal pancreatectomy and splenectomy was done in a case of ACC. 2 cases which recurred underwent redo surgery.

**Conclusion:**

Majority of Adrenal tumors are functional at the time of presentation and their clinical presentation varies diversely. Proper functional workup, surgery and follow up is required for proper management of these tumors.

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**ASIAN INSTITUTE OF NEPHROLOGY AND UROLOGY 2 VIDEO SESSION 1**

**AV 1. ZERO ISCHEMIA ROBOTIC PARTIAL NEPHRECTOMY IN A SOLITARY POLYCYSTIC KIDNEY**

**AUTHOR: KONDAKINDI PURNA CHANDRA REDDY**

**INSTITUTION: ASIAN INSTITUTE OF NEPHROLOGY AND UROLOGY, HYDERABAD.**

**Introduction and objectives:**

ADPKD apart from causing chronic kidney disease is also associated with increased risk of renal carcinoma. The risk for recurrent tumours is also high. Hence the preferred approach for management of tumours in these patients is parenchymal preserving approach. However, the anatomical configuration is completely deformed making partial nephrectomy extremely complex. We present a case of robotic assisted laparoscopic partial nephrectomy for tumour in solitary kidney in a patient with ADPKD to highlight the technical improvisations and modifications needed to overcome the challenging scenario.

**Materials and methods:**

A 44 year old male was admitted for management of right renal tumour picked up on regular follow up of his ADPKD and associated CKD. He had undergone
left sided radical nephrectomy for renal cell carcinoma 2 years back. Considering the solitary kidney status and his CKD, nephron preserving approach was planned. He was evaluated with computed tomography and magnetic resonance imaging for better delineation of tumour. It was a 5.0cm lesion in midpolar area. Robotic assisted laparoscopic partial nephrectomy with intraoperative ultrasound guidance was planned. Port placement was conventional. Colon was mobilised. Hilum was dissected and control of main renal artery was taken with a vessel loop. The procedure was planned in a non-clamping zero ischemia approach to prevent ischemia induced parenchymal injury in view of pre-existing CKD. Intra-operative ultrasound examination was done. Overlying cysts were decompressed. Tumour was excised with adequate margins. Feeding vessels to the tumour were sutured. Hemostasis was secured. Limited renorrhaphy was done in view of cysts all around. Hemostatic agents applied and peri-nephric fat closed over it.

Results:
The total duration of procedure was 110 min. The drop in haemoglobin was 0.9mg/dl. Since the procedure was performed in a non-clamping approach, there was no warm ischemia induced. Surgical margins were free. Histopathology report was clear cell carcinoma with Fuhrman grade 2. The creatinine increased post-operatively from 2.58mg/dl to 2.9mg/dl. Post-operative recovery was uneventful. Patient was discharged on 3rd post-operative day.

Conclusions:
Patients of ADPKD and underlying CKD with renal tumours present a complex scenario for nephron preserving surgery. Despite the anatomical complexity, partial nephrectomy can be performed safely with due improvisations and proper planning.

AV2. DYNAMIC SUSPENSION SUTURE FOR DEALING WITH MEDIAN LOBE DURING ROBOTIC RADICAL PROSTATECTOMY

2. DR SANJAI ADDLA, APOLLO CANCER INSTITUTES, HYDERABAD

Introduction: Undertaking Robotic prostatectomy on a patient with a large median lobe is a surgical challenge. Various approaches and tips and tricks
have been suggested to help leaners as well as advanced Robotic surgeons to deal with this surgical complexity.

We define our technique of using a dynamic suspension suture to alleviate the problem.

**Objective:** To demonstrate the technique of using a dynamic suspension suture to manage a large median lobe during Robotic radical prostatectomy

**Technique:**

Once the anterior bladder neck is incised and a large median lobe is visualized, the right hand instrument is changed to a needle holder and the assistant hands in a 1-0 vicryl suture, precut to a size of 30cm. The suture is taken through the median lobe and lifted towards the anterior wall. The suture is then suspended using the third arm and the needle parked onto the anterior abdominal wall. Further lateral dissection is carried out and each time the suture is taken increasingly towards the posterior wall/trigone of the bladder until the whole of the median lobe is lifted up and the ureteric orifices visualized.

**Results:** This technique has been used for the last 4 years in managing large prostates as well as large median lobes. The largest prostate till date operated successfully using this technique weighed 330gms.

**Conclusions:** Dynamic suspension suture is a useful technique to facilitate Robotic radical prostatectomy in patients with a large median lobe.

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AV3. LAPAROSCOPIC TRANSVESICAL COMMON SHEATH URETERIC REIMPLANTATION FOR VESICOURETERIC REFLUX DISEASE.

**AUTHORS:** PAVAN A P, BANUTEJA REDDY, HARI KRISHNA M, SUDEEP B, BHARGAV REDDY, VEDA MURTHY P, MALLIKARJUNA REDDY N

**INSTITUTION:** DEPT. OF UROLOGY, NARAYANA MEDICAL COLLEGE, NELLORE, ANDHRA PRADESH
**Objectives:** To report our technique of laparoscopic Transvesical common sheath ureteric reimplantation for Vesicoureteric reflux disease.

**Introduction:** Vesicoureteric reflux is common entity in female for upper tract deterioration, diagnosing it early and treating it is best way to safeguard the upper tracts, transvesical approach is one of the safe and better ways of ureteric reimplantation. We present our experience of laparoscopic transvesical common sheath ureteric reimplantation for grade IV reflux in a left duplex system.

**Materials & methods:** A 30 year old lady presented with pain abdomen since 1 month associated with fever and vomiting. Investigated and diagnosed to have a left duplex moiety with grade IV vesicoureteric reflux. Planned for left ureteric reimplantation. Cystoscopic revealed both ureter in a common sheath, planned for a laparoscopic transvesical common sheath ureteric reimplant.

**Results & Observations:** patient recovered well, operating time was 90 mins with minimal blood loss and post operative MCU is awaited

**Conclusions:** we report our technique of Transvesical laparoscopic common sheath ureteric reimplantation which needs immense experience and skill.

AV4. OUR EXPERIENCE WITH PEDIATRIC RIRS IN LESS THAN 20 KG
DR V CHANDRAMOHAN , PREETI UROLOGY BHOSPITAL, HYDERABAD

Recent years has seen a marked increase in pediatric stone disease. They are more commonly associated with metabolic, anatomical or infectious conditions, for which we see an increased incidence of recurrences. High possibility of recurrence, enhance the necessity of minimal invasion in pediatric case. RIRS is one of the most common procedure done for renal stones less than 2 cm. Pediatric RIRS requires a special care and some technical skills for better outcome and with minimal complications.

We describe our method of RIRS done in less than 20 kg children.

**Case details:**

CASE 1
One and half year old child diagnosed with left upper uretic calculus 7 mm and renal pelvic calculus of about 8 mm. child was pre stented for 15 days and then taken up for Left RIRS as described in the video

CASE 2:
7 yr old female child, diagnosed with right pelvic partial staghorn stone. She underwent RIRS in 3 sittings and had complete stone clearance. We describe the procedure in the video

CASE3:
6 yr old female child, left lower pole stone of about 1 cm. reffered to our center after a failed attempt for PCNL which had lead to fecal fistula. Fistula was managed conservatively and was reffered to us 8 months later. It was a bifid system with the stone in one of the lower calyx . it was completely powdered and was discharged on 2 nd POD.

CASE 4:
1 yr old male child diagnosed with bilateral ureteric cal with left renal stone of about 8 to 1 cm. this child underwent bilateral Dj stenting followed with URSl on right side. Child had fever in the postoperative period. Urine culture had grown e coli. Fever was controlled with IV antibiotics and was taken for RIRS on left side in the same admission. Post operatively child improved and was discharged.

Conclusion:
RIRS is feasible in children with least complication and fast recovery.

AV5. ROBOTIC PARTIAL NEPHRECTOMY FOR RIGHT LOWER POLE ANGIOMYOLIPOMA
DR. V.SURYA PRAKASH, DR.SRIKANTH REDDY, DR. K.SESHU MOHAN, DR.MILAN PATEL,DR.RAJESH REDDY
YASHODA HOSPITAL, SOMAJIGUDA, HYDERABAD, TELANGANA, INDIA

Angiomyolipoma (AML) is a rare benign tumors with incidence of 0.1 to 0.2% in general population and more frequent in females. Composed of an intimate admixture of blood vessels, smooth muscle cells and fat and hence the name. They occur at many sites, more commonly in the kidney. The presentation is usually incidental, some can present with flank pain or with retroperitoneal
haemorrhage in adults. AMLs are seen in 25-50% of patients with Tuberous sclerosis.

Case summary: 54 yrs old female known case of right flank pain of 4 months duration. She had right renal lower pole angiomyolipoma since 8 years and is on regular follow-up. Initial size of tumor was 2 cm and now increased to 5.5 cm in size. Recent CECT abdomen revealed 5 x4.3cm right lower pole mass showing several enhancing vessels with predominantly fat density lesion (-50 to 80 HU) suggesting Angiomyolipoma.

Robotic partial nephrectomy was done with clear margins. Postoperatively patient recovered well and post op histopathology confirmed AML.

AV6. LAPAROSCOPIC DONOR NEPHRECTOMY - OUR EXPERIENCE
- G SRINIVAS ,STAR HOSPITALS, HYDERABAD

Laparoscopic donor nephrectomy has become the procedure of choice for retrieval of kidney in live related renal transplants. At our institution we have performed 62 left LDN from June 2016 to June 2018 through Trans peritoneal approach using 3 ports Technique, of the 62 cases 40 were female and 22 were males. We have avoided LDN in right sided donor nephrectomies. Mean age of the Donors was 45 years. Mean baseline creatinine was 0.79 mg/dl and baseline Hb% was 13.22 Gm/dl. A total of 60 patients had single renal arteries and two had double renal arteries. Early arterial bifurcation was noted in 2 cases. Single Renal vein was noted in 61 cases, double renal veins in one case and delayed confluence in one case. Ureteral duplication was noted in one case, which were joining in the upper one third. Mean operative time was 130 minutes and average warm ischemia time was 7 minutes. Transient elevation of serum creatinine was noted in the early post operative period, except for 1 donor all others had normal serum creatinine during follow up at 3 months. Five donors developed Kocak-modified Clavien-Dindo classification grade-1 complications (fever-3, wound infection-2) and 1 donor had grade-IIa complication, paralytic Ileus requiring naso gastric tube aspiration. None of our patients required blood transfusions. None required conversion to open surgery.

AV7. RENAL CELL CARCINOMA WITH A SUPRA HEPATIC IVC THROMBUS (Level III) IN A MORBID OBESE PATIENT
INTRODUCTION: Renal cell carcinoma with extension of IVC thrombus associated with post operative morbidity and mortality. We report our experience on operating on a morbid obese patient with right renal carcinoma with supra hepatic IVC (Level II) thrombus.

Methodology: A 56 years old asymptomatic gentlemen detected to have right renal mass on health check up, on Ultrasound right renal mass with infiltration of renal vein and IVC. On further evaluation with CECT abdomen was found thrombus extending into supra hepatic IVC. Right radical nephrectomy with IVC thrombectomy and IVC repair was performed involving a multidisciplinary team – Urology, Gastro surgery, CTVS, Cardiac anaesthetist. During the procedure continuous trans oesophageal ECHO (TEE) monitoring was done.

Result: Post operatively patient recovered well. Discharged on POD 8, at 3 months follow up patient is doing well.

Conclusion: A multi disciplinary team with proper planning is essential prior to treating a case of Renal cell carcinoma with supra hepatic IVC thrombus is safe to avoid complications.

ASIAN INSTITUTE OF NEPHROLOGY AND UROLOGY VIDEO SESSION 2:

AV8. USE OF FLEXIBLE URETEROSCOPE IN RECURRENT PYELONEPHRITIS

VARDHANA REDDY, NANDYAL KIDNEY AND UROLOGY CENTRE, NANDYAL

ABSTRACT

Flexible ureterorenoscopy is increasingly used as a first-line treatment for patients with renal lithiasis and proximal ureteral calculi, with varying success rates among different groups. With advancement in technology, improvement in flexible ureteroscope and ancillary equipment, more complex procedures can be performed include management of calculus disease, diagnostic procedures, endoscopic management of upper tract tumors and endoureterotomy or endopyelotomy. The aim of this paper is to provide a usefulness of flexible ureterorenoscopy in chronic urinary tract infection with hidden matrix calculi in kidney not shown in routine investigations.
INTRODUCTION
To investigate the recurrent pyelonephritis and for the successful treatment of kidney stone disease. We are presenting the outcomes of flexible ureteroscopy and stone treatment for patients with recurrent pyelonephritis with matrix calculi not showing in routine investigations.

CASE STUDY
A 40 Yrs female presented with high grade fever with chills, Left loin pain 3 days, Vomittings with dysuria since 3 days. Past history of recurrent left pyelonephritis since 5 years, seen and treated by many urologists many times, Usg multiple times shown small non obstructive renal calculi, Culture positive got treatment according to c/s, present CT scan showed 15mm calculus obstructing at PUJ with duplex left renal pelvis, serum creatinine 1.8 mg% , leucocytosis (18000).We did Left uretereroscopy, under vision stone pushed into left lower pelvis and DJ stenting done. After stabilization posted for Left RIRS Lower pole identified Flex x2 passed, stone seen wrapped in matrix material laser done with 272 micron fibre (12hz x 0.5 J =6 watts ). To let out matrix material suction with 10 cc syringe used. After completion of the calculus which was shown in ct / ivp just to confirm of the complete clearence flex x2 passed into upper calyx of lower pole moiety and found around 2 cm matrix calculus. Lasing and aspiration technique applied and complete clearance achieved An another 56 yr male patient diabetic presented with high grade fever, Right loin pain with serum creatinine 6.0 mg%, CT scan showed 9mm Rt PUJ calculus. DJ stenting done , s.cr decreased upto 3 mg% in 10 days. Posted for Rt RIRS after lasing of the calculus which was shown in ct scan there is another matrix calculus of size 1.5 cm in lower calyx. Lasing and aspiration done, achived complete cllereance.

CONCLUSION
We are presenting the outcomes of flexible ureterorenoscopy and stone treatment for patients with recurrent pyelonephritis with matrix calculi not showing in routine investigations. In patients with long standing clinical symptoms & signs of pyelonephritis if routine investigations are normal then search for matrix calculus hide in kidney with Flexible ureteroscope. Technique to let out matrix material and clots gentle aspiration with 10ml syringe.
AV 9. ROBOTIC EXCISION OF RETROPERITONEAL FIBROSIS & MULLERIAN DUCT CYST-AINU PRIZE VIDEO SESSION
DR.SREEDHAR KAMMELA, DR.SRIDEVI

DR.SREEDHAR’S KIDNEY, ANDROLOGY & IVF INSTITUTES, MEHDIPATNAM & GACHIBOWLI,

First case: A 35 year old male presented vomiting and facial edema of 10 days duration. On investigation, he had mild bilateral hydronephrosis. He had rising serum creatinine from 1.3 to 4.5mg% in 2 weeks. Hemoglobin was 13gm% indicating acute onset. His CT scan showed bilateral mild to moderate hydronephrosis and both ureters were displaced medially at L3,4 level. Retroperitoneal plaque was noticed encasing both ureters at L3-5 level. In view of rising creatinine, bilateral DJ stenting was done. Both DJ stents could be passed easily. Serum creatinine came down to 1.6mg% in one week time. After his general condition improved, he was taken up for robotic excision of retroperitoneal plaque. First right side plaque was excised with patient in lateral decubitus position. Then patient was shifted to left kidney position and RPF was excised. The retroperitoneal plaque was thick, tough and both ureters were freed with difficulty and they were covered with peritoneum and available omentum. Total operating time was 190 minutes and postoperative recovery was good and patient discharged on 2nd post-op day. The biopsy of RPF plaque was negative for malignancy. Patient is on follow-up for 18 months and is asymptomatic and serum creatinine is stable at 1.8mg%.

2) Second case: A 23 year old male presented with hypogonadism (wt 93 kg) and he was testosterone supplementation. His chromosome karyotyping 46 XY. He had left undescended testis for which orchidopexy was done 2 months back. Biopsy of that testis showed no spermatogenesis. His USG and pelvic MRI showed 15 x 12 x 9 cm large Mullerian duct cyst which contained some fluid inside. His other internal organs were normal and there was no sign of ovaries in his pelvis. The large Mullerian duct cyst was situated between bladder and rectum. It was dissected off robotically and could be peeled off easily. The right horn of the Mullerian duct cyst looked like Fallopian tube and left tube was rudimentary. The Mullerian duct cyst had mucus and some blood. The Histopathology showed it to be Mullerian duct cyst with aborted Fallopian tube formation. No Malignancy.

The da Vinci Si robot of great help in complicated pathologies because of magnification, 3 D visualization, endo-wrist instrumentation, surgical dexterity and accurate pinpoint dissection which is essential at such depths & complicated anatomy.
AV 10. MICROSURGICAL VARICOCELECTOMY: our experience


Institution: Dept. Of Urology, Narayana Medical College, Nellore, Andhra Pradesh

Objectives: To report our experience of microsurgical varicocelectomy for a primary infertility in symptomatic patient.

Introduction: Primary infertility is on a growing trend across the world and one of the correctable causes includes varicocele. We present our experience of microsurgical varicocelectomy in primary infertile men.

Materials & methods: A 25 year old gentlemen married since 3 years evaluated for primary infertility found to have grade III varicocele on both sides (L>R). Scrotal Doppler showed tortuous dilated veins of size 4mm with reversal of flow on valsalva, semen analysis reported to be oligospermia with 20% motile sperms, testosterone level - 550ng/dl, FSH- 6.7mIU/ml and LH- 8mIU/mL. Planned for microsurgical varicocelectomy. We have performed around 27 cases.

Results & Observations: Patient underwent microsurgical varicocelectomy and was discharged on POD 1. Semen analysis repeated after 3 months revealed oligospermia with 36% motile sperms.

Conclusions: Microsurgical varicocelectomy needs experience and scores over the conventional laparoscopic varicocelectomy surgery in primary infertility treatment.

AV 11. ADVANTAGES OF THULIUM LASER PROSTATECTOMY
POLEBOYINA VAMSI KRISHNA, K RAMA RAJU, K PRASAD RAJU, AHMED NAZEER, PATIL ABHIJIT, AKINAPALLY VARUN
CARE HOSPITAL, BANJARA HILLS, HYDERABAD

Recently, Thulium Laser prostatectomy has established itself as one of the standard procedures for the minimally invasive surgical treatment of benign enlargement of Prostate. It has unique features of good absorption in water,
shallow depth penetration (0.5 mm) and better tissue vaporisation and hemostasis making it suitable for use in patients with large glands, associated comorbidies like cardiac or cerebrovascular disease, chronic kidney disease, high risk patients, etc. In this video we are presenting various techniques of use of Thulium Laser for prostate surgery and technical aspects of tissue morcellation, and their advantages over minimally invasive surgical procedures.

AV12.TITLE: LAPAROSCOPIC ADRENALECTOMY
AUTHORS: DONTHULAKASHINATHAM, BHATTARAM SURYA PRAKASH, SANGAL ANKUR, CHARAG AAKIB HAMID, SATHISH,
YASHODASUPERSPECIALITY HOSPITAL, MALAKPET, HYDERABAD, TELANGANA, INDIA

Introduction and Objective:
Minimally invasive surgery on the adrenal is performed more and more often. Laparoscopic adrenalectomy has become a standard procedures in many centers. We present a video demonstrating laparoscopic right adrenalectomy in a patient with right adrenal mass.

Method:
A middle aged female was incidentally found to have a right adrenal mass on routine checkup. She underwent evaluation and planned for right laproscopic adrenalectomy.

Result:
The patient is on follow up. She is doing well and is asymptomatic.

Conclusion:
Laparoscopic adrenalectomy may be performed safely and effectively for selected adrenal masses.
Objective:
To report on the surgical technique of Video Inguinal Lymphnodal dissection (VEIL) for a penile squamous cell carcinoma

Introduction –
Groin lymph node dissection (GND) in carcinoma of penis is associated with high incidence of complications like flap necrosis infection etc. We present our technique with video endoscopic inguinal lymphadenectomy (VEIL), a minimally invasive approach to avoid complications of GND

Methods:
A 49 years man presented with ulcerative growth over penis and palpable inguinal lymph nodes, was evaluated and underwent wedge biopsy revealing squamous cell carcinoma. FNAC lymphnodes negative for malignancy. CECT abdomen done showing bilateral subcentimetric lymphnodes. He was managed with antibiotics for 2 weeks and found to have persistant palpable lymphnodes. He underwent wide local excision of growth and Video Endoscopic Inguinal Lymphadenectomy was performed. Technical aspects are described.

Results & Observations:
There were no intra or postoperative complications. Blood loss was minimal. Hospital stay was 3 days. HPE revealing reactive hyperplasia. The patient resumed his normal activity after 1 week. Patient doing well at 6 months follow up.

Conclusion:
Video Endoscopic Inguinal Lymphadenectomy (VEIL), is a feasible minimal access surgery option for penile carcinoma with similar oncologic outcomes to open, avoiding morbidity to patient.

AV14.PERCUTANEOUS HERNIOTOMY: A SIMPLE, PAINLESS AND COSMETIC ALTERNATIVE
PRESENTING AUTHOR:RAJ KUMAR SHARMA
CO-AUTHORS: J JAYARAJU, K V BHARGAVA REDDY, P VEDA MURTHY REDDY, N MALLIKARJUNA REDDY

DEPARTMENT OF UROLOGY AND RENAL TRANSPLANTATION, NARAYANA MEDICAL COLLEGE, NELLORE, ANDHRA PRADESH

Objective: To report on the surgical technique of Percutaneous Herniotomy.

Introduction – Inguinal Hernia repair is one of the most commonly performed surgical procedure. Open technique is the gold standard but misses 16-20% of contralateral side hernias. Percutaneous Herniotomy on the other hand is an easy technique, does not need special equipment, provides excellent visual exposure, permits to review the contralateral side and with it avoids unnecessary inguinal exploration, less complications, comparable recurrence rates and improved cosmetic results compared to traditional open approach. No need to dissect the spermatic vessels and preservation of the testicular integrity. In incarcerated hernia it permits to review the bowel irrigation. Finally it is possible to do in very short time avoiding the exposition to CO2.

Methods: Laproscopic approach with one 5mm port in umbilicus and on the affected side in a percutaneous way were inserted. A needle was introduced through the peritoneum of internal inguinal ring avoiding the vas deferens and vessels. Catching the tip of the needle, it was returned in a subcutaneous way to its original insertion site. It was then knotted, closing the inguinal ring.

Results: The procedure was completed laparoscopically. The herniotomy was performed. There were no intra or postoperative complications.

Conclusion: Percutaneous Herniotomy is a day care, simple, painless and excellent cosmetic alternative to open surgery.

AINU VIDEO SESSION 3

AV15. LAPAROSCOPIC RADICAL PROSTATECTOMY - OUR EXPERIENCE
DR V CHANDRAMOHAN, PREETHI UROLOGY HOSPITAL, HYDERABAD

Abstract:
Several treatment options exist for the treatment of localized prostate cancer. Laparoscopic radical prostatectomy is one of the accepted method of treatment. It requires an advanced laparoscopic training to accomplish. As this procedure is not routinely done in all hospitals, we describe our method of laparoscopic radical prostatectomy video.
Case description:
65 yr old male, presented with LUTS, on evaluation had elevated PSA of 14ng/ml. PR- a small hard nodule was felt on right lateral wall. TRUS biopsy – gleason 4+3 =7 , 8 out of 12 core positive. All core more than 50 % tumor. No lymphovascular invasion.

Bone scan- negative

Multiparameter MRI- localized prostatic lesion, no extracapsular extension and no enlarged lymphnode.

After through preoperative workup patient was taken up for laparoscopic radical prostatectomy as described in the video.

Operative procedure:
Patient was placed in trendelenberg position. Primary 12mm port placed just above the umbilicus followed with 3 secondary ports on Rt and left lateral abdominal wall. Posterior approach was done, mobilizing seminal vesicals and division of both the vas was done. Bladder was dropped. Both endopelvic fascia incised and prostate was mobilized. DVC was ligated with 2-0 vicryl stich. Bladder neck was divided and prostate was mobilized. Prostatic apex was divided followed with bilateral lateral pedical ligation and divison. Prostate was removed. Rocco stich was placed. Vesicourethral anastomosis done with 3-0 monocryl suture over 16 fr foleys catheter. Specimen was removed by pfannenstiel incision.

Post operative period was uneventful. Discharged on 4 th POD. Foleys removed at 3 weeks. Voided well had minimal stress incontinence which improved over a period of 6 months.

Follow up at 6 months PSA -0.002 ng/ml, no pads used.

Conclusion:
Laparoscopic radical prostatectomy is feasible in centers where robotics are not available.
AV16. LAPAROSCOPIC PARTIAL NEPHRECTOMY FOR ENDOPHYTIC RENAL MASS WITH RENAL SCORE 11X
DR. K. SESHU MOHAN, DR. V. SURYA PRAKASH, DR. SRIKANTH REDDY, DR. MILAN PATEL, DR. RAJESH REDDY
YASHODA HOSPITAL, SOMAJIGUDA, HYDERABAD, TELANGANA, INDIA

INTRODUCTION:
With the rapid evolution of laparoscopic techniques, the surgical modality of Partial Nephrectomy has expanded to laparoscopic partial nephrectomy (LPN) with low overall morbidity, faster postoperative recovery, and comparable oncological outcomes.

Laparoscopic partial nephrectomy for endophytic mass is difficult and challenging in view of difficult tumor localization and close proximity to renal sinus structures.

Case summary:
59 years old female presented with incidental detection of left renal mass. No history of LUTS, hematuria, and no abnormality found on physical examination.

Triphasic CECT abdomen revealed ill defined heterogeneously enhancing SOL measuring 4.6x3.6x3.3cm noted in upper pole of left kidney with progressive enhancement in arterial/venous phases with mild washout in delayed films.

Patient underwent laparoscopic partial nephrectomy with leaving around <30% of normal parenchyma, post op histopathology reported as eosinophilic variant of clear cell carcinoma (Furhmann grade IV). Patient on follow up for 3 months and follow up CECT revealed no residual/recurrent mass with normal contrast enhancement.

AV17. CONTINENT CATHETERISABLE STOMA WITH AUGMENT AND MACE FOR CHILD WITH URINARY AND FECAL INCONTINENCE
SUDEEP BODDULURI, HARI KRISHNA M, BANUTEJA REDDY P, PAVAN A P, JAYARAJU J, VEDAMURTHY REDDY P, MALLIKARJUNA REDDY N
DEPT. OF UROLOGY, NARAYANA MEDICAL COLLEGE, NELLORE, ANDHRA PRADESH.

Introduction: The major obstacle in a patient with neurogenic bowel and bladder is stool and urinary incontinence. There is a major impact on quality of life in these children. We present our experience with Monti and MACE creation for the management of stool and urinary incontinence.

Case Details: A 13Yr Male presented with bowel and bladder incontinence. Constipation was being managed by daily enema. H/o recurrent episodes of pyelonephritis was present. Operated for meningomyelocele at 6 months of age. On examination there was diffuse excoriation of skin in the gluteal and perineal region. Creatinine at presentation was 1.78mg/dl. MCUG was done which showed grade V VUR with small capacity bladder with an open bladder neck. DTPA renogram was done which revealed relative less function on the right side. Patient underwent Augmentation cystoplasty with bilateral ureteric reimplantation with spiral monti creation for clean intermittent catheterization and MACE for continence enema.

Post operatively patient was complaint with CIC and enema. Follow up creatinine at 3months was in normal limits.

Conclusion: Monti and MACE in children with urinary and fecal incontinence makes them socially acceptable.

AV18. LAPAROSCOPIC RADICAL NEPHRECTOMY FOR T4 RCC INfiltrating INTO COLON AND TAIL OF PANCREAS
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NARAYANA MEDICAL COLLEGE, NELLORE

INTRODUCTION AND OBJECTIVE
Renal cell carcinoma(RCC) is the most common malignancy of kidney accounting for 3% of adult malignancies. Laparoscopic radical nephrectomy has become the preferred method of surgery. However, in T4 tumours the technique has to be modified depending on the infiltration and invasion of the tumour.

To report our operative technique for the laparoscopic management of T4 RCC.
MATERIALS AND METHODS

Patient was diagnosed to have T4 RCC of left kidney with loss of fat planes with colon and infiltrating into the tail of pancreas. Patient was planned for a laparoscopic left radical nephrectomy.

RESULTS AND OBSERVATIONS

During the procedure, we went trans-mesocolic and ligated the vascular pedicle in the renal hilum. Next we have separated the dense adhesions between the abdominal wall and mass. We have done left colectomy and distal pancreatectomy with splenectomy and specimen was removed en mass. Radical nephrectomy was completed laparoscopically. A flank incision was given to retrieve the specimen and a colo-colic anastomosis was performed. Total operative time was 2 and ½ hours. There were no intra or postoperative complications. Hospital stay was 6 days. Patient has resumed his normal activities immediately after discharge.

CONCLUSION

Laparoscopic radical nephrectomy is feasible in T4 tumours with adjacent organ infiltration.

AV19. LAP ADRENAL CYST

RAJAN BANSAL, J JAYARAJU, K V BHARGAVA REDDY, P VEDA MURTHY REDDY, N MALLIKARJUNA REDDY

DEPARTMENT OF UROLOGY, NARAYANA MEDICAL COLLEGE, NELLORE, ANDHRA PRADESH

Introduction – Cystic lesions of the adrenals are rare and mostly found either as the endothelial cysts or the pseudocysts. Laparoscopic adrenal cystectomy is preferred technique and feasible option available. Intervention is indicated whenever they are more than 5cm and symptomatic. We demonstrate our procedure of laparoscopic adrenal cyst excision.
**Methods:** A 35-year-old male presented with complaint of right loin pain and was evaluated with USG abdomen and CECT abdomen which showed 86x64x65mm cystic lesion with mural calcification seen in right adrenal gland with mass effect. **Surgical procedure:** Patient in lateral position, 10mm camera port and other 3 working one 10mm and two 5mm port was placed. Adrenal cyst was dissected and attachment to base of liver and IVC released.

**Result:** The entire procedure was completed laparoscopically.

**Conclusion:** Laparoscopic management of the adrenal cyst excision is safe, effective, minimally invasive, with minimal blood loss and short duration of hospitalization.

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**AV20. LAPAROSCOPIC ADRENOENPHRECTOMY FOR EXTRADRENAL SUPRARENAL PHEOCHROMOCYTOMA, A CHALLENGE**

**Presenting Author:** Parag K Jaipuriya  
**Narayana Medical College, Nellore**

**Abstract:**

**Introduction and objective:** Extra adrenal pheochromocytoma are uncommon near the renal hilum. Most common location being the organ of Zuckerkandl. Most patient present with palpitations, sweating, headache and hypertension. 24 hrs urinary Metanephrines are most sensitive to diagnose the pheochromocytoma. This patient with an extradrenal pheochromocytoma at the renal hilum was a challenge.

**Materials:** A 20 years old female patient investigated for antenatal hypertension was incidentally diagnosed to have left suprarenal mass, 24 hrs urinary metanephrines was 54.35 mcg/24hrs (74-297 mcg/24hrs), normetanephrines was 4482.46 mcg/24 hrs (73-808 mcg/24 hrs), 24 hrs urinary cortisol was 245.43 mcg/24 hrs, Contrast enhanced CT showed a well defined enhancing mass with central necrotic areas in left suprarenal region close to splenic vessels and lifting the tail of pancreas superiorly. MRI abdomen showed a well defined heterogeneous signal intensity mass in the left suprarenal region suggestive of pheochromocytoma.

**Procedure:** Patient in Right lateral position. Transabdominal laparoscopic adrenonephrectomy done. Two 10mm & two 5mm ports placed. Left colon
reflected, dissection along medial border to left adrenal gland to expose the adrenal vein done. Mass was adhered to the left renal hilum with renal artery going through the mass with bulging renal vein. Access to renal artery was not possible anteriorly, it was approached posteriorly by flipping the kidney. Mass could not be separated, hence adrenonephrectomy was done after clipping and cutting the renal artery, renal vein and adrenal vein.

**Conclusion:** Extra adrenal supra renal pheochromocytoma adhered to renal hilum is a challenge managing laparoscopy.

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**AV21. LAPAROSCOPIC NEPHRECTOMY FOR XANTHOGRANULOMATOUS PYELONEPHRITIS**

**DR. MILAN PATEL, DR. V. SURYA PRAKASH, DR. SRIKANTH REDDY, DR. K. SESHU MOHAN, DR. RAJESH REDDY**

**YASHODA HOSPITAL, SOMAJIGUDA, HYDERABAD, TELANGANA, INDIA**

**Introduction:** Xanthogranulomatous pyelonephritis (XGP) is an atypical and severe form of chronic renal infection characterized by destruction of the renal parenchyma and its replacement by masses of lipid laden macrophages. The clinical presentation is nonspecific, and investigation often reveals a non-functioning kidney. Preoperative diagnosis can be difficult even with imaging as XGP mimics malignancy on Computed tomography. The treatment is usually nephrectomy and laparoscopic approach though difficult has been used in XGP.

**Case summary:** we are presenting two cases of xanthogranulomatous pyelonephritis presenting with calculous pyonephrosis with non functioning kidney. Laparoscopic nephrectomy was done. The procedure was difficult due to dense adhesion. Patients recovered well and postoperative histopathology confirmed diagnosis of XGP.

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**AV22. ROLE OF MINI PERC IN TREATING RENAL AND UPPER URETERIC CALCULI - OUR INSTITUTIONAL EXPERIENCE**

**RAHUL TEJ PAPPALA KHAMMAM**-
PCNL is a well-established treatment option for patients with large and complex renal calculi. In order to decrease morbidity associated with larger instruments like blood loss, postoperative pain and potential renal damage, a modification of the technique of standard PCNL has been developed. This is performed with a miniature endoscope via a small percutaneous tract (11–20 F) and was named as minimally invasive or mini-PCNL. This method was initially described as an alternative percutaneous approach to large renal stones in a pediatric patient population. Furthermore, it has become a treatment option for adults as well, and it is used as a treatment for calculi of various sizes and locations. However, the terminology has not been standardized yet, and the procedure lacks a clear definition. Nevertheless, mini-PCNL can achieve comparable stone-free rates to the conventional method, even for large stones. It is a safe procedure, and no major complications are reported. Although less invasiveness has not been clearly demonstrated so far, mini-PCNL is usually related to less blood loss and shorter hospital stay than the standard method.

Methods: We here present our institutional experience on MINI PERC in adults and children. Procedure is performed in the prone position, percutaneous access (18-Fr sheath) was established by placement of an access needle into the intended calyx under fluoroscopic guidance or combined with ultrasound guidance for complete obstruction by stones while the contrast agent cannot transit. Pneumatic or ultrasonic probes were used throughout ureterorenoscopy for lithotripsy. The ureteral stents and nephrostomy tube were placed at the end of the procedure. Mean drop in hemoglobin, operative time, success rate, hospital stay, and complications were assessed.

Here we share our technique through video demonstration where we discuss the steps of procedure and manipulation into upper ureter and calculi retrieval.

PREETI UROLOGY & KIDNEY HOSPITAL BEST MODERATED POSTER PRIZE

PU1.TITLE: MINIMALLY INVASIVE RECONSTRUCTION OF URETERIC STRICTURES SECONDARY TO ENDouroLOGICAL INTERVENTIONS
PRESENTING AUTHOR: VSPA RAVICHANDER OLETI
CO-AUTHORS: MALLIKARJUNA.C, K.PURNACHANDRAREDDY, GHOUSE. S.M, BENDORGERI. M.T, RAGOORI. D.R, ENGANTI. B.
INSTITUTE: ASIAN INSTITUTE OF NEPHROLOGY & UROLOGY, HYDERABAD, INDIA.

Introduction& Objectives:
Occurrence of ureteric stricture after upper urinary tract endourological intervention is one of the dreaded post-operative complications. The strictures may be either ischemic or non-ischemic in nature depending on the mechanism of injury (i.e., mechanical or thermal trauma). The presentation is varied and management of these complications is challenging. We present our case series of minimally invasive reconstructive management of ureteric strictures occurring after endourological intervention.

Materials and Methods:

This is a retrospective observational study conducted at Asian Institute of Nephrology and Urology, Hyderabad from September 2014 to June 2018. All patients treated by minimally invasive reconstructive procedures by laparoscopic or robotic method for ureteric strictures secondary to endourological intervention were included in the study. Patient demographic details, prior intervention history and details of pre-operative workup were noted. Anatomical and functional assessment of each patient was done. Intravenous urography (IVU), contrast CT scan, radionucleotide scan and retrograde pyelography were done to confirm diagnosis and details related to length, location of stricture and functional status. The procedure was selected based on the length and location of ureteric stricture. Intra and post-operative details were noted. IVU was done 3 month after stent removal. Patients with minimum of 3 month follow-up were included in the study.

Results:

A total of 25 patients underwent laparoscopic or robotic reconstruction for ureteric strictures. Out of these, 15 patients had history of previous endourological intervention. The 15 patients were included for the study. The most common intervention was ureteroscopic stone retrieval, seen in 11 patients. 4 patients had lower ureteric strictures and remaining 11 had upper ureteric strictures. 6 patients underwent ureteroureterostomy, 4 underwent Boari flap reconstruction and 2 underwent ureteric reimplantation. Buccal mucosal graft augmentation ureteroplasty, ureteropyelostomy and stricturoplasty were done in one patient each. Post-operative complications included paralytic ileus in 1 patient, readmission for fever in 1 patient. 1 patient needed double-J stenting for flank pain after stent removal. All 15 patients had unobstructive drainage at 3 month post stent removal IVU.

Conclusion:

Ureteric strictures secondary to endourological interventions present in varied patterns with different location and lengths of strictures. Individualization of the reconstructive procedure is essential for successful outcome. These complex reconstructive procedures can be performed with good outcomes even with laparoscopic or robotic approaches with the additional benefits of minimally invasive intervention to the patients.
PRESENTING: AUTHOR: DR. SRINATH REDDY

CO-AUTHORS: MALLIKARJUNA C, BHAVATEJ. E, PURNACHANDRA REDDY, MOHD TAIF BENDIGERI, DEEPAK RAGOORI, MOHD. SYED GHOUSE, PABITRA K MISHRA.

INSTITUTE: ASIAN INSTITUTE OF NEPHROLOGY & UROLOGY, HYDERABAD.

Introduction and objectives:

There are various surgical techniques and approaches defined for bulbar urethroplasty for bulbar urethral strictures. Double-face Buccal mucosal graft (BMG) urethroplasty is one of the techniques indicated in near obliterator bulbar urethral strictures. It can be performed by either ventral (dorsal inlay-ventral onlay) or dorsal (ventral inlay-dorsal onlay) approach. We evaluate our experience, technique and short-term outcomes of Double-face BMG (dorsal inlay-ventral onlay) urethroplasty for bulbar urethral strictures.

Material and Methods:

We retrospectively analyzed patients with bulbar urethral strictures (more than 2cm) who underwent Double-face BMG urethroplasty at our institute from January 2015 to March 2018. Patients clinical data, preoperative parameters, uroflometry and imaging by retrograde urethrogram (RGU) was recorded. Technique of Double-face BMG urethroplasty was done by ventral approach, wherein dorsal-inlay and ventral-onlay BMG was placed. Patients with minimum follow-up of 6 months were included in the study. Patients follow-up data of AUA symptom score and uroflometry was assessed at 3rd monthly for the 1st year and at 6 months thereafter. A successful outcome was defined as normal urinary flow rate without any obstructive voiding symptoms. The data was compared with contemporary data of patients who underwent Dorsal onlay BMG urethroplasty for bulbar urethral strictures at our institute.

Results:

Total of 54 patients with the mean age of 43 years, who underwent BMG urethroplasty for bulbar urethral strictures were enrolled in the study. Of these, 30 patients underwent Double-face BMG urethroplasty (Group 1)) and 24 patients underwent Dorsal onlay BMG urethroplasty (Group 2). Mean stricture length (3.5 cm (Group 1) vs 4 cm (Group 2) was comparable between the groups. There was significant improvement in peak flow rates at 6 months ([G1: 25 ± 4 ml/sec; G2: 24 ± 5±1.86 ml/sec]) when compared to preoperative
parameters ([G1: 6 ± 2 ml/sec; G2: 5 ± 2 ml/sec]) in both groups. Failures were noted in 4 patients (13.3%) in group 1 versus 3 patients (12.5%) in Group 2, which were managed with internal urethrotomy and dilatations.

Conclusion:

Double-face BMG urethroplasty (ventral approach) is a feasible option for near obliterate bulbar urethral strictures, strictures involving the proximal bulbar urethra and in obese patients. Our study of Double-faced BMG urethroplasty showed similar results and acceptable short-term outcomes when compared with Dorsal onlay technique of BMG urethroplasty.

PU3. MALIGNANT GIANT PHEOCHROMOCYTOME IN A PATIENT WITH VON RECKLINGSON DISEASE

AUTHORS: DIMPLE KUMAR(PG), NARENDRA & PVLN MURTHY,

THE DEPARTMENT OF UROLOGY & RENAL TRANSPLANTATION, KAMINENI INSTITUTE OF MEDICAL SCIENCES, SREEPURAM, NARKETPALLY, TELANGANA.

Malignant pheochromocytoma is a rare disease and surgical resection is the only curative treatment. There are no definitive histological or cytological criteria of malignancy, as it is impossible to determine this condition in the absence of advanced locoregional disease or metastases.

We report a case of a large pheochromocytoma with retroperitoneal lymphnode metastases in a patient suffering from Vonrecklingson disease, which was treated with surgery. The literature is reviewed to evaluate tumour features and criteria to distinguish between benign and malignant pheochromocytomas.

Case Report: The patient, a 47-year-old woman with Vonrecklingson disease, normotensive, was being investigated for left upper abdominal swelling associated with pain since 6 months. Patient evaluation revealed a non-tender, firm and immovable abdominal mass in the epigastrium and left hemiabdomen. She is also suffering from Von recklinghausen disease which manifested as multiple cutaneous neurofibromas.

Investigations including 24-hour urine catecholamines (nor-metanephrine, metanephrine and vanilmandelic acid), CBC, RFT and LFT were normal. No abnormalities were present at red and white blood cells count. Abdominal computerized tomography (CT) scan demonstrated a $17 \times 11 \times 21$ cm mass located in the left retroperitoneum, which occupied a large part of the abdominal cavity. It had a significant aberrant vascularization and displaced the adjacent structures anteriorly. The left kidney was displaced downwards and was infiltrated. The left suprarenal gland could not be identified. With a chevron
incision, abdomen was explored and the tumor as well as the left kidney along with enlarged paraaortic lymph nodes were removed. The blood pressures were stable throughout the surgery except in the last phase of resection when the pressures were raised and controlled by Sodium nitroprusside. Post op period was uneventful.

Pathologic evaluation revealed a malignant pheochromocytoma with a lone lymph node metastasis; the other lymph nodes were normal. She developed left clavicular metastasis after 12 months follow up.

PU4. : ISOLATED RENAL HYDATID CYST – A RARE CASE REPORT

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INSTITUTION : NIZAM’S INSTITUTE OF MEDICAL SCIENCES, HYDERABAD, TELANGANA, INDIA.

Introduction and Objective

Hydatid disease is mainly caused by Echinococcus Granulosus. It is a zoonotic disease. Liver is the most common site of involvement. Renal involvement is seen in 2% to 3% of patients, and isolated involvement of the kidney is even rarer. It manifests as a slow growing cystic lesion. We present a rare case of primary left renal hydatid cyst with presenting feature of left lumbar pain.

Case Details:

A 45 years old gentlemen presented to our outpatient department with pain left loin for 4 months. Patient had no other complaints. On clinical evaluation patient was normal and on ultrasonography found to have 9x4 cm cystic lesion in the left kidney. CECT demonstrated well defined cystic lesion with peripheral wall calcification without significant post contrast enhancement measuring 9.1*7.8*10 cm. There are multiple peripherally arranged hypo densities with central stroma suggestive of hydatid cyst. Patient underwent left simple nephrectomy after complete evaluation. The diagnosis of a hydatid cyst was confirmed on histo-pathological examination. Patient recovered well and discharged on fifth day postoperatively. He was followed up for 8 months and had no complaints.
Conclusion
Though isolated renal hydatidosis is very rare, it should be considered as a differential diagnosis while evaluating for a renal mass, so that adequate precautions can be taken during surgery to prevent accidental rupture and devastating complications. Most cases of renal Hydatidoses are dealt with open surgery like cystectomy with pericystectomy. More study is needed on such rare cases of primary renal Hydatidoses to define a standard treatment modality after comparing the various available options. Minimally invasive approach needs to be studied in comparison with the open approach.

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PU5. XANTHOGRAANULOMATOUS PROSTATITIS WITH ACUTE URINARY RETENTION

DR. RAJESH REDDY KRV, DR. V. SURYA PRAKASH, DR. D. SRIKANTH REDDY, DR. K. SESHU MOHAN, DR. MILAN PATEL

YASHODA HOSPITAL, SOMAJIGUDA, HYDERABAD, TELANGANA, INDIA

INTRODUCTION:

Xanthogranulomatous type prostatic inflammation is a rare clinical entity that can resemble prostatic adenocarcinoma in clinical studies and digital rectal examination (DRE). Definitive diagnosis is only possible with histopathological examination of transrectal ultrasound (TRUS)-guided prostate biopsies or surgical specimens.

Case summary: A 55 yr old male patient presented with history of acute urinary retention and on Foley catheter to us. On evaluation, patient had history of two failed catheter free trials. There was grade 2 prostatomegaly with hard nodule in right lobe of prostate, serum PSA was 9.84ng/ml. Ultrasound showed 35cc prostate.

TRUS guided prostate biopsy was done in view of suspicion for malignancy. TRUS biopsy revealed xanthogranulomatous prostatitis. Patient underwent Transurethral resection of prostate and post operative biopsy confirmed the diagnosis of xanthogranulomatous prostatitis. Postoperatively patient is doing well.
Primary amyloidosis of the urinary bladder is a rare condition of extracellular deposition of amyloid, a protein with a fibrillary structure. The case presentation often mimics bladder malignancy.

Case report:

A sixty-five years old male patient presented with irritative voiding symptoms (urinary frequency, urgency) and painless haematuria for few weeks. There was no positive finding about past medical and personal history. Physical examination was normal. Urinalysis was normal except few rbc. USG KUB showed bilateral kidneys normal. Prostate 22cc and PVR 30 cc. Cystoscopy showed grade 1 prostate, grade 1 bladder trabeculations with hyperemia of bladder mucosa. Small suspicious growth noted near the right ureteric orifice and trigone. Biopsy showed localized atypical hyperplasia, infiltration of lymphocytes and eosinophils. Positive Congo red stain confirmed the diagnosis of amyloidosis. Transurethral fulguration of the growth done. Patient recovered well and discharged on POD-3. LUTS and haematuria did not happen during the followup period. and cystoscopy showed no recurrence.

Discussion:

Amyloidosis is characterised by the extracellular deposition of proteins. Systemic amyloid can occur anywhere in the urinary tract, including the kidney, renal pelvis, ureter, urethra or corpora, primary localised bladder amyloidosis is a rare urological disease with approximately 200 cases reported in the literature.
Localized amyloidosis presented as nonspecific presenting symptoms and uncharacteristic cystoscopy appearances. Radiological appearances mimic inflammatory or a neoplastic lesion. Cystoscopy may show nodular-to-polypoidal, single or multiple masses. Congo red staining shows the classical apple-green birefringence under polarized light.

Management is transurethral fulguration/resection of the growth. Intravesical instillation of dimethyl sulfoxide and oral colchicines therapy have also been performed with promising result. Regular followup with cystoscopy is recommended.

Conclusion:

Primary amyloidosis of the urinary bladder is a rare disease, presenting as lower urinary tract symptoms and painless haematuria. Radiological imaging mimicks malignancy or inflammatory lesion. Cystoscopy may show nodular-to-polypoidal, single or multiple masses. Biopsy is necessary to make a diagnosis. Congo red stain confirms amyloidosis. Transurethral fulguration/resection are the best options for the treatment. Regular followup with cystoscopy is required.

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**PU7. PERINEAL MALIGNANCY MASQUERADING AS CHRONIC INFLAMMATORY PATHOLOGY**

**PRESENTING AUTHOR: PARAG K JAIPURIYA**

**CO-AUTHORS**: PAVAN A P, BANU TEJA REDDY, HARI KRISHNA M, SUDEEP B, JAYARAJU J, BHARGAVA REDDY KV, P VEDAMURTHY REDDY, N MALLIKARJUNA REDDY

**Abstract:**

**Introduction and objective**: Urethral carcinoma accounts for 1% of urothelial malignancies. Urethral carcinoma presenting as periurethral abscess is very rare and usually presents late. **Methods**: 

**Case 1**: A 72 year old male patient presented with periurethral abscess with surrounding induration. Twice debridement was done with biopsy revealing well differentiated squamous cell carcinoma. Contrast enhanced CT scan of abdomen and pelvis was done to further evaluate which showed irregular heterogeneous enhancing soft tissue lesion with left inguinal and right obturator lymph node spread.
Case 2: A 47 years male presented with chronic non resolving periurethral abscess, underwent thrice debridement and biopsy revealed moderately differentiated squamous cell carcinoma.

Results: Wide excision with skin graft was done. Both patients were advised chemoradiation.

Conclusions: We are sharing our experience due to its rarity and to consider urethral cancer and biopsy in a recurring lesion in a chronic inflammatory conditions of the perineum.

PU8. SQUAMOUS CELL CARCINOMA IN AUGMENTED BLADDER

PRESENTING AUTHOR: RAJ KUMAR SHARMA

CO-AUTHORS: J JAYARAJU, K V BHARGAVA REDDY, P VEDA MURTHY REDDY, N MALLIKARJUNA REDDY

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ABSTRACT:

INTRODUCTION:

Augmentation Cystoplasty is the gold standard treatment for refractory neurogenic overactivity or low bladder compliance. This procedure aims to protect the upper urinary tracts by resorting to a low-pressure bladder and to improve the quality of life by achieving continence in these patients. However, Augmentation cystoplasty is a risk factor for cancer. Adenocarcinoma is the most common entity in augmented bladders but Squamous cell carcinoma, is still very rare. Bacteriuria-N-nitroso compounds, chronic inflammation, urinary hyper-osmolal conditions, inherent abnormality and perturbation in cell to cell interactions have been postulated to be incriminating factors.

METHODS:

A lady 37 years old female, k/c/o s/p GUTB, who had augmentation cystoplasty 17 years back, presented with hematuria and pain abdomen with a hard mass palpable in anterior vaginal wall of 4x3cm. On CT ill defined isodense mass to uterus located inferolateral to augmented bladder on left side causing left proximal HDUN. RK gross HDN. LK PCN and mass biopsy was done, which was negative. TURBT was done, which showed SCC on HPE.
Right Lap Simple Nephroureterectomy with Anterior Pelvic Exenteration with ileal conduit was done for the SCC. HPE showed well differentiated SCC infiltrating muscularis and adjacent intestine. Lymph nodes were negative.

**RESULT:**

Patient recovered well and Hospital stay was uneventful. PCN and drain removed. Ileal conduit was healthy and draining well.

**CONCLUSION:**

Aggressive surgical management including radical cystectomy or pelvic exenteration performed in good performance status patients offers a better quality of life and improved survival.

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**PU9. FEMALE BMG URETHROPLASTY**

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DEPARTMENT OF UROLOGY, NARAYANA MEDICAL COLLEGE, NELLORE, ANDHRA PRADESH

Introduction – Only 3-8% of women who present to urologists with voiding complaints have diagnosis of outlet obstruction. Most female urethral stricture are iatrogenic caused by prolonged urethral catheterization or surgical repair of diverticulum and fistula. Buccal mucosal graft (BMG) is one of the effective technique to treat female urethral stricture.

Methods: Seven women of age 40 to 65 years (mean age=56) from Dec 2017 to June 2018 with urethral stricture disease who underwent urethral reconstruction using dorsal BMG were considered. All patients were evaluated preoperatively with USG abdomen, Uroflowmetry, Voiding cystourethrography, Post void residual volume, Maximum flow rate and length of stricture were measured respectively.

Results: On follow up in all cases, Uroflowmetry after catheter removal and USG was done, which shows good flow of urine and insignificant post void residual urine.

Conclusion: The dorsal laying of buccal mucosa graft in urethral stricture gives good results and is a feasible option.
INTRODUCTION AND OBJECTIVE:

A ureterocele is a cystic dilatation of the distal ureter. The incidence ranges from 1/500 to 1/1,200. They are more common in women. Prolapsed ureteroceles are very rare and pose a challenge to diagnosis and management as very few cases are reported till date and not well described in the literature. We report a case of prolapsed ureterocele in a young female.

METHODS:

A 26Y female patient presented with chief complaints of prolapsed mass per urethra and difficulty in micturition for 1 day. On examination initially there was large mass of size 5x6cm in size prolapsing from the urethra which was congested, tender and tense. Vaginal opening can be separately seen. Manual reduction was unsuccessful. A 14 French foleys catheter can be placed without much difficulty and the catheter was easily mobile all around the swelling. MRI abdomen and pelvis was done which showed a mass arising from the left ureter. Cystoscopy was done which showed a large intravesical ureterocele. A incision was given over the ureterocele which caused the decompression of the system and a patch of the wall is excised.

RESULTS:

After MRI, Cystoscopy was done which showed a large intravesical ureterocele. A incision was given over the ureterocele which caused the decompression of the system and a patch of the wall is excised.

CONCLUSION:
Prolapsed ureterocele is a very rare presentation. A high index of suspicion is necessary to diagnose and manage the case. It can be confused with prolapsed urethra. Incision of the ureterocele is a safe and effective treatment and if the ureterocele is very large excision of a patch of the wall may be necessary.

Title: INFECTED URACHAL CYST
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Introduction and Objective
The urachus is a midline tubular structure located behind the abdominal wall infraumblically. It connects bladder dome to the umbilicus. There are four types of congenital urachal remnant anomalies of which urachal cyst is second most common. Overall it is a rare anomaly. We are presenting a case report of infected urachal cyst.

Methods
55 year old female presented with suprapubic pain, dysuria, loss of appetite and weight loss. On evaluation she was diagnosed of infected urachal cyst with doubtful possibility of neoplastic lesion. She was planned for laparotomy and excision of cyst.

Results
Patient had a smooth post operative recovery. She was discharged on fifth postoperative day and was on regular follow up thereafter.

Conclusion
Infected urachal cyst is a rare entity and can be a challenging diagnosis. It can be effectively cured by surgical intervention.
PU12. MULTIPLE MYELOMA WITH TESTICULAR INVOLVEMENT: A CASE REPORT AND REVIEW OF THE LITERATURE

DR. MILAN PATEL, DR. V. SURYA PRAKASH, DR. D. SRIKANTH REDDY, DR. K. SESHU MOHAN, DR. RAJESH REDDY KRV

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Introduction: Multiple myeloma is 1% of all malignancy and 10% of haematological malignancy. It’s a malignant transformation of the plasma cells in the bone marrow. Extra medullary plasmacytoma (EMP) involves axial skeleton, gastrointestinal tract, liver, lymph nodes, skin, central nervous system and rarely testis. Multiple myeloma of the testis constitutes 0.03 to 0.15% of all testicular malignancy.

Case summary: A 55 year male patient presented with painless firm right testicular swelling. On examination there was hard testicular mass present and on Ultrasonography of scrotum there was ill defined heterogenous hypoechoic lesion measuring 3.8x2.9 cm in right testis with hypervascularity. Testicular Tumor markers were negative.

He was diagnosed and treated for multiple myeloma 3 years ago in the form of chemotherapy. Patient underwent right high inguinal orchidectomy. Histopathological examination suggestive of involvement of interstitium of the testis with immature and binucleate plasma cells. Patient was followed with bone marrow biopsy and serum electrophoresis but there was no systemic recurrence of multiple myeloma.

Session 2:

PU13. ISOLATED EPISPADIAS IN ADULT FEMALE WITHOUT URINARY INCONTINENCE – A CASE REPORT

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Isolated female epispadias without bladder extrophy is a rare congenital anomaly. The presenting features of female epispadias are urinary incontinence and abnormal anatomical features. Often bladder capacity is reduced as a consequence of lack of filling. External genitalia can be varied. Most severe cases are those which involve entire length of urethra and bladder neck.

Case Report
We report a case of 29 years married female, with H/o continent vaginal voiding since childhood, H/o recurrent UTI last 2 years. H/o 3 abortions and a LSCS surgery, P/V – urethra not seen. CECT abdomen showing bicornuate uterus, small left kidney with parenchymal thinning noted in both kidneys. DMSA revealed asymmetric kidneys, with larger right kidney contributing most towards overall renal function. Left kidney much smaller relative function being 21%. Cystoscopy done showing bladder neck opening into anterior vaginal wall, B/I ureteric orifices seen. Urethral plate seen extending from bladder. MCUG shows normal bladder capacity.

**Results** - Urethral reconstruction was planned and plane was created between urethral plate and vagina. Vaginal flap raised dorsally and neourethra created over 16 fr foley. Vaginoplasty done. At 1 month follow up patient is doing well.

**Conclusion** - Diagnosis of female urethral anomalies and its treatment possess a great challenge. The objectives of surgical repair include achievement of urinary continence with preservation of the upper urinary tracts and the reconstruction of functional and cosmetically acceptable genitalia.

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**PU14: A RARE CASE OF RECURRENT PARAGANGLIOMA OF URINARY BLADDER**

**AUTHORS:** DR YOGESH TORKADI, DR RAHUL DEVRAJ, DR VIDYASAGAR, DR RAMACHANDRIAH, DR RAGHUVEER, DR RAM REDDY, NIMS, HYDERABAD, TELANGANA, INDIA.

**INTRODUCTION AND OBJECTIVES**

Paraganglioma of the urinary bladder are tumors of chromaffin tissue originating from the sympathetic innervations of the urinary bladder wall. Bladder paraganglioma is an extremely rare tumor with a high recurrence rate. We report a rare case of Recurrent paraganglioma of urinary bladder.

**METHODS**

A 20 year old female patient came to our OPD with complaints of burning sensation during micturation and Intermittent Hematuria since 1 month. Past history patient had similar complaints 8 months back, over a duration of 6 month, for which she underwent evaluation and diagnosed with Bladder mass. For which TURBT done 4 month back, Histopathology report confirmed of paraganglioma of bladder. On clinical examination Vitals stable, positive findings are Chromogranin A-184 ng/ml(<108), 24 Hr Urine Metanephrine-1760 (600-1600). On imaging USG (A+P): urinary bladder distended with 4.4 x 1.9 cm lesion in region of trigone on left side with increased vascularity, CT (A+P): Pedunculated heterogeneously enhancing lesion arising from posterolateral wall of Urinary bladder of size 2.5 x 2/5 x 1.3 cm, no evidence of extravasical spread seen. Our provisional diagnosis was recurrence of bladder tumour.
RESULTS

Based on past history and imaging investigation recurrence noted. So partial cystectomy done. Histopathological examination confirmed paraganglioma of urinary bladder, since last 6 months pt is in follow up with us, with no evidence of recurrence.

CONCLUSIONS

Bladder paragangliomas tend to recur and metastasis, so lifelong follow-up with appropriate history, annual measurement of plasma and urinary catecholamine levels, imaging study and cystoscopy is essential.

PU 15. RENAL AUTO-TRANSPLANTATION
Dr G SRINIVAS, STAR HOSPITAL, HYDERABAD

We have performed two Renal Auto-transplantations in our institute in the last two years. First patient was a 16 years old who is a known case of renal artery stenosis with hypertension, had earlier underwent right renal artery stenting 2 years back. Follow up evaluation revealed re-stenosis distal to the stent. Patient was taken up for auto transplantation, due to the previous stenting only a very short viable arterial segment was noted close to the hilum, which was anastamosed to the internal iliac artery. Postop period was uneventful and required a single anti hypertensive drug at the time of discharge.

The second patient is an 8 year old child with hypertension due to the stenosis of left main renal artery with post stenotic aneurysmal dilatation with decreased renal function on left side. Patient underwent left renal auto transplantation after excision of the stenotic and aneurysmal segment of the renal artery. Postoperative period was uneventful, his anti hypertensive drug dosing was decreased.

PU 16. MIGRATED RIGHT DJ STENT INTO DUODENUM: A RARE CASE PRESENTATION
MOHSIN QUADRI, NITESH JAIN., VENKATA SUBHRAMANIAN
APOLLO MAIN HOSPITALS, CHENNAI, TAMIL NADU, INDIA.

This 59 year old gentleman known diabetic presented with right flank pain, dull type, on and off since 3 months, no hematuria, no lithuria, no fever.
3months ago underwent right DJ stenting elsewhere at periphery for right hydronephrosis with retroperitoneal mass, CT guided FNAC from Retroperitoneal mass revealed acute suppurative inflammation for which longterm antibiotics used consequently RP mass resolved.

Right flank pain with history of right DJ stenting elsewhere, on evaluation Sr.creatinine of 1.6mg/dl, CECT whole abdomen revealed Contracted right kidney showing hydronephrosis, thinned out renal paremchyma and poor excretion of contrast with malposition of upper end of right DJ stent into the second part of duodenum(Pyelo-duodenal fistula) and changes of acute pyelonephritis in the right kidney.

After Anaesthetist clearance and glycemic control he underwent Laparoscopic right DJ stent removal with repair of the duodenal rent with right nephrectomy under general anaesthesia.

Intra operatively with great difficulty identified right ureter amidst of dense adhesions, duodenum found stuck ro right renal pelvis, on mobilisation of duodenum from renal pelvis upper end of DJ stent found which was divided and retrieved out, Duodenum repaired and right nephrectomy done. His perioperative period was uneventful, on nil by mouth with continous ryles tube drainage for 3days and started liquids, tolerated liquid diet well and discharged on POD-5 on soft diet with resolving azotemia (Sr.creatinine reduced to 1.3 from 1.6mg/dl). He is asymptomatic and followed up in OPD after 3months with no complications.

PU17. GIANT RENAL PELVIC CALCULUS REMOVED LAPAROSCOPICALLY IN TOTO IN A FUNCTIONING KIDNEY
DR.K.SESHU MOHAN, DR.V.SURYA PRAKASH, DR.SRIKANTH REDDY, DR. MILAN PATEL, DR. RAJESH REDDY
YASHODA HOSPITAL, SOMAJIGUDA, HYDERABAD, TELANGANA, INDIA

Introduction: very large renal pelvic calculi are unusual because the growth of stones is depend on continued secretion of urine. since most stones cause arrest of renal function before they reach giant proportions, stones weighing more than 100 grams not often encountered. There are very few cases reported in literature weighing more than 150 grams, and stone located at renal pelvis which were removed laparoscopically in toto with preserved renal function.

Case summary: 66 years female patient presented with on and off right loin pain since 6 years. no other complaints are present. no significant past medical or surgical history present. on evaluation Plain CT KUB revealed 8x6cm calculus with 1250 HU, with well preserved cortical thickness and few air pockets around right kidney. Intravenous Pyelogram revealed malrotated right kidney with
delayed excretion of contrast into right ureter at 2 hours. Right DJS kept and patient was on IV antibiotics for 1 week in view of pyuria. Laparoscopic pyelolithotomy was done after 1 week and stone was removed totally. Stone weighted 197 grams and measuring 9x7cm; patient recovered well and post operative on follow up since 2 months.

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**PU18. LONG SEGMENT URETERIC STRicture SECONDARY TO METASTATIC BREAST CARCINOMA**

**DR.K.SESHU MOHAN, DR.V.SURYA PRAKASH, DR.SRIKANTH REDDY, DR. MILAN PATEL, DR. RAJESH REDDY**

**YASHODA HOSPITAL, SOMAJIGUDA, HYDERABAD, TELANGANA, INDIA**

Introduction: Metastasis of the ureter is rare and 342 cases have been described in the world literature, the first report having been published in 1909. Neoplasms of the stomach, breast, urinary bladder and prostate are the primary tumors that most frequently metastasize to the ureter and about 7.8% are metastases from carcinoma of the breast. Ureteric metastasis presenting as long segment stricture is a very rare presentation.

Case summary: A 50 year old female is a known case bilateral breast carcinoma, operated on left side with modified radical mastectomy with lymph node dissection. Right breast infiltrating growth received chemotherapy and both were invasive ductal carcinoma with ER,PR negative with Her 2 neu positive status.
Patient presented with raised creatinine 1.5 and she was on left DJ stent exchange since 1 year for left ureter stricture. Urine cytology was positive for malignant cells. Left nephroureterectomy was done. Intraoperatively dense adhesions present around kidney and ureter. Ureter wall was very hard to cut, dense desmoplasic changes noted around ureter. Post operative biopsy with immunohistochemistry confirmed high grade metastatic from breast carcinoma.

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**PU19. IMPACTED GIANT VESICAL STONE: A RARE CASE REPORT**
INTRODUCTION AND OBJECTIVE
Bladder stones comprise 5% of urinary tract stones. Giant vesical calculi weighing more than 100 gm are universally uncommon. Fewer than 30 reports of a stone that weighs more than 500 g are available in the English literature. We report a case of large vesical stone weighing 500gms and causing obstructive uropathy.

METHODS
Patient was a 50 year-old man presented with 6 months history of intermittent lower abdominal pain and obstructive and irritative lower urinary tract symptoms. Serum creatinine levels on presentation was 5.8mg/dl. Plain abdominal radiography showed a large bladder stone. Ultrasonography revealed bilateral hydroureteronephrosis and a large bladder stone approx 8x7 cm.

RESULTS
Patient underwent open cystolithotomy. A stone approx.8×6×7 cm in size and approximately 500grams in weight was removed. Patient was evaluated in the outpatient clinic one month after operation. The patient had decreased hydroureteronephrosis on follow-up ultrasonography, and serum creatinine levels decreased to 1.8 mg/dl

CONCLUSION
This case report emphasis that patients with intermittent lower abdominal pain and lower urinary tract symptoms must be suspected of bladder stones and evaluated with radiological investigations.

PU20. Open Calyceal Diverticulectomy in a case of giant calyceal diverticulum
DR.RAJESH REDDY KRV, DR.V.SURYA PRAKASH, DR.D. SRIKANTH REDDY, DR. K.SESHU MOHAN, DR.MILAN PATEL
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PRESENTER: DR.RAJESH REDDY KRV, DNB RESIDENT

Calyceal diverticula are rare outpouchings of the upper collecting system that likely have a congenital origin. Stones can be found in up to 50% of calyceal
diverticula, although, over the combined reported series, 96% of patients presented with stones. Diagnosis is best made by intravenous urography or computed tomography urogram.

CASE SUMMARY: A 55 yr old male presented with Rt loin pain of 6 months duration. On evaluation by CT urogram he had 8x7 cm cystic lesion arising from Rt kidney with contrast pooling into the cyst. Retrograde pyelography confirmed a large calyceal diverticulum with multiple filling defects in it. Open calyceal diverticulectomy was done. Patient is on follow-up and is doing well.

PU21. UROTHELIAL CANCER IN A PATIENT WITH CLINICAL DIAGNOSIS OF THIMBLE BLADDER.

AUTHOR: JITENDRA K BARAD, RAHUL DEVRAJ, VIDYASAGAR S, RAMACHANDRAIKAH, RAGHUEER P, CHARAN GV, RAM REDDY CH.

INSTITUTION: NIZAM’S INSTITUTE OF MEDICAL SCIENCES, HYDERABAD.

INTRODUCTION: GUTB as the second most common extrapulmonary TB and urinary bladder is involved in one third cases of GUTB. In acute phase, bladder changes are usually non-specific which gives rise to irritative voiding symptoms. Chronic inflammation causes mural fibrosis and contracture leading to reduced compliance and capacity, known as thimble bladder manifesting as frequency of micturition and incontinency. We are presenting a case which clinically behaved as GUTB but intraoperative frozen showed it as a malignancy.

METHOD: 47-year-old male patient presented to OPD with complains of frequency, burning micturition, urgency for last 2 months. no h/o fever, pain abdomen, hematuria. no incontinency. 2 years back patient was given ATT for 9 months outside as empirically. history of right uretero lithotomy, done 15 years back (outside).no h/o DM, HTN, CVA, CAD, COPD.CUE and urine C & S was normal. Routine blood tests are normal except sr creat which was 2.4. on USG bilateral hydroureteronephrosis was there with decreased capacity of bladder and bladder wall thickening. on NCCT KUB THIMBLE BLADDER with focal wall thickening present and bilateral gross hydronephrosis was there. on MCUG thimble bladder with right side grade v reflux and left grade I reflux. Urine for AFB and malignant cell negative. Urine TB PCR was also negative. On DTPA RK ERPF 106 ml/min and LK 18 ml/min. A clinical diagnosis of thimble bladder due to GUTB was made and patient planned for augmentation cystoplasty.

OBSERVATION: Intraoperatively, the bladder dome was indurated, stony hard on palpation and surface irregular from outside. Frozen sent and came to be s/o high
grade urothelial carcinoma. Plan changed and radical cystectomy with bilateral pelvic LN dissection and ileal conduit was done. Final HP report came as T4a, N1, Mx.

CONCLUSION: literature are lacking on this topic and bladder cancer don’t present as thimble bladder without any mucosal lesion or metastasis, but from this case we learnt that in case of contracted bladder there is a possibility and we should be aware of it..

PU22.A RARE CASE OF SMALL CELL NEUROENDOCRINE TUMOR OF THE URINARY BLADDER

AUTHORS: RAHUL NAIR, RAHUL DEVRAJ, VIDYASAGAR S, RAMCHANDRIAH, RAGHUVEER P, CHARAN GV, RAM REDDY CH.

DEPARTMENT OF UROLOGY – NIMS, HYDERABAD.

INTRODUCTION:

Neuroendocrine tumors (NETs) can be found in most organs, as well as in the urinary bladder. Most of the characters of the NETs are shared by all the tumors regardless of its anatomic site. In the bladder, NETs comprise less than 1% of all bladder tumors and can be found in a pure form or intermixed with urothelial carcinoma and its variants. Bladder NETs are classified into 2 subtypes: carcinoid tumor and neuroendocrine carcinoma, which is further subdivided into small cell (SCC) and large cell neuroendocrine carcinoma. SCC of the bladder comprises only 0.5 to 1 % of all primary bladder malignancies. It most commonly presents in the seventh decade of life with a male to female ratio of 2:1 to 5:1. Here we present a rare case of small cell neuroendocrine cell in a 70 year old male patient.

METHODS:

A 70 year old male patient came to opd with chief complaints of burning micturition, painless hematuria associated with clots since 2 months. Patient is known hypertensive with no past history of any genitourinary disorders. No h/o smoking. O/E – G.C – Fair and Vitals stable. USG showed B/L renal cortical cysts with 34x22mm, 12x11mm and 10x9 mm focal isoechoic lesion with no vascular flow noted in urinary bladder. CECT (abdo+pelvis) showed 4.1x3.5x2.3 cm lobulated mass lesion arising from the right anterolateral wall of bladder with post contrast enhancement. Urine cytology for malignant cells were negative. Cystoscopy revealed papillary growth of size 1x1 cm at neck, 1.5x1cm at right lateral wall of bladder 3 cm above right ureteric orifice and sessile growth of 3x4 cm in right lateral wall.
TUR Biopsy of the lesions were done (muscle included). No metastatic lesions were found on evaluation.

RESULTS:

Histopathology of the biopsy specimen revealed non invasive high grade urothelial carcinoma. Patient underwent radical cystoprostatectomy with ileal conduit and bilateral pelvic lymph node dissection. Histopathology of the specimen revealed high grade small cell neuroendocrine malignancy of bladder with no lymph node involvement. (p T3a N0 Mx). On IHC synaptophysin and TTF1 were positive.

CONCLUSION:

Bladder SCC is a very rare entity with worse prognosis in view of its delayed presentation compared to urothelial carcinoma and subsequently increased risk of metastasis.
It is a highly chemosensitive tumor and adjuvant chemotherapy prolongs 5 year survival rate.
Patient requires life long follow up due to high chances of recurrence.

PU23.A RARE CASE OF SPORADIC BILATERAL PHEOCHROMOCYTOMA IN A PEDIATRIC PATIENT
AUTHORS: RAHUL NAIR, RAHUL DEVRAJ, VIDYASAGAR S, RAMCHANDRIAH, RAGHUVEER P, CHARAN GV, RAM REDDY CH

DEPARTMENT OF UROLOGY – NIMS HYDERABAD.

Introduction:

Pheochromocytoma(PCC) is a sympathetic paraganglioma that originates from chromaffin cells. The reported incidence of PCC is 2-8 cases per million. 10 – 20 % of these occur in pediatric age group. Although rare pediatric pheochromocytoma is the most frequently encountered endocrine neoplasm in children. 20 % of pheochromocytomas were found to be bilateral. Here we report a case of bilateral pheochromocytoma in a pediatric patient.

Methods:

A 13 year old male child came to our outpatient with the chief complaints of headache, palpitations and sweating. He had no relevant family history or any major medical co morbidities. On examination he was found to have pallor, P.R – 120/min, B.P – 190/100 mm of Hg. Free plasma nor-metanephrine was 1239 pg/ml(<196). His free plasma metanephrine, 24 hour fractionated urinary metanephrines were within normal limits. USG showed grossly enlarged right
adrenal gland (6.2x5 cm) with lobulated appearance with slightly hyperechoic to hypo and anechoic areas within. Left adrenal gland of 5.7x4 cm with solid and cystic components. CECT with adrenal protocol was done which showed B/L kidneys to be normal. Large peripherally enhancing mass lesion of size 6.9x4.5 cm in right adrenal gland abutting the liver and IVC and peripherally enhancing lesion of size 5.6x4 cm of left adrenal gland. Genetic testing for VHL syndrome and MEN 2 syndrome were negative.

Results:

Based on the above biochemical and imaging findings a diagnosis of bilateral pheochromocytoma was made. Patient was started on alpha blockers followed by beta blockers after 5 days. After adequate optimization of patients blood pressure and preoperative work up patient underwent right adrenalectomy followed by left adrenalectomy. Histopathology report confirmed the diagnosis of pheochromocytoma.

Conclusions:

Although pheochromocytoma is a rare neoplasm in the pediatric age group, it should be considered as a possible diagnosis in children presenting with malignant hypertension. Bilateral pheochromocytoma is a rare entity seen in pediatric age group with patient requiring life long steroid and aldosterone supplementation.

PU24. EOSINOPHILIC CYSTITIS MIMICKING BLADDER TUMOUR – A RARE CASE REPORT
AUTHORS: KOUSIK A, RAHUL DEVRAJ, VIDYASAGAR S, RAMCHANDRIAH, RAGHUVEER P, CHARAN GV, RAM REDDY CH
DEPARTMENT OF UROLOGY – NIMS HYDERABAD.

Introduction:

Eosinophilic cystitis is a rare and a poorly understood clinico–pathologic entity which mimics bladder tumours. It is characterised by extensive local eosinophilic infiltration of all layers of bladder wall. Even though many aetiological factors have been proposed, the exact mechanism of the lesion remains obscure. The most common presenting symptoms are urinary frequency, dysuria, gross/ microscopic haematuria, suprapubic pain and urinary retention. Here we are presenting a 69-year-old gentleman who presented with hematuria and was found to have eosinophilic cystitis.

Methods;
A 69 year old gentleman came to our outpatient with the chief complaints of painless gross hematuria with passage of clots for 2 months duration. No other LUTS. He had no relevant family history or any major medical co morbidities. He had no history of bronchial asthma, hypertension, diabetes mellitus or drug allergy. He is a known smoker (30 pack years). On examination he was found to have pallor, other general physical examination was unremarkable. A routine haematological examination showed peripheral eosinophilia (10%). His biochemical profile was within normal limits. Analysis of midstream urine showed RBCs- 25-30 / HPF, pus cells -3-5 /HPF and few epithelial cells. Urine culture showed no growth. Urine cytology showed squamous cells and no atypical cells.

USG s/o mild focal irregular bladder wall thickening (5mm) involving right lateral wall.

CECT s/o mild focal irregular bladder wall thickening(12mm) along right lateral wall anteriorly showing mild enhancement on contrast study.

Cystoscopy : growth along the junction of dome and Right lateral wall of size 3x1.5 cm.

Transurethral resection of the lesion was carried out and the sample was subjected to a histopathological examination

Results :

Grossly, the specimen consisted of grey white soft tissue fragments which measured 1.5x1x0.5 cm. Microscopy showed an ulcerated transitional epithelium with stromal oedema and congested blood vessels. There was diffuse infiltration of mucosa by eosinophils and few lymphocytes, with areas of haemorrhage and inflammatory necrosis. There was no evidence of malignancy or parasites in the sections which were studied.

Conclusions :

Eosinophilic cystitis is a very rare entity with varying clinical features and it should be included in the differential diagnosis of various mass lesions of bladder. A histological examination is the gold standard method, which should be used for establishing the diagnosis. Early detection and a prompt treatment are expected, for better outcomes. Treatment of eosinophilic cystitis is based on resection of bladder lesion, followed by treatment with antihistaminics, corticosteroids and antibiotics, as well as removal of possible allergens.
PU25.
“DORSAL ONLAY BUCCAL MUCOSAL GRAFT URETHROPLASTY IN THE MANAGEMENT OF STRICTURE URETHRA IN FEMALE WITH VAGINAL FIBROSIS POST RADIATION”

AUTHORS:
Dr. Sandeep Maheswara Reddy Kallam, Dr. Prakasa Rao Busam, Dr. Prabhakara Rao Medavankala

INSTITUTE:
Guntur Medical College & Government General Hospital, Guntur, Andhra Pradesh, India.

INTRODUCTION:
Female urethral stricture is an under diagnosed cause of bladder outlet obstruction in females. The possible aetiology may be idiopathic, infection, Radiation induced, difficult catheterisation with subsequent fibrosis, prior urethral surgery or trauma. A 65 year old female Patient presented to OPD with complaints of poor urinary stream since 4 years on repeated dilatations since 3 years. Obstructive LUTS present. H/o Carcinoma Cervix 20 years back underwent Radiotherapy. No active growth noted. Biopsy shows no malignancy noted. Patient under spinal anaesthesia and in dorsal lithotomy position, Buccal Mucosal graft is harvested under Local anaesthesia. An inverted U-shaped incision was then made at the suprameatal position extending from the 3 o'clock to 9 o'clock position. A surgical plane was developed between overlying clitoral bodies and underlying urethra. The urethral wall was incised dorsally with stricture extending from meatus to the mid urethral stricture at 12 o'clock until normal urethral lumen appeared. The normal proximal urethra was identified as it accepted a 26 F bougie freely. 18 Fr Foley catheter was then placed. Mucosal surface of the free buccal graft was sutured to the margins of the urethrotomy defect by interrupted sutures using 4-0 Vicryl and quilted. Vulvar mucosa was approximated with 4-0 Vicryl. Foley catheter was left indwelling for 14 days. Patient was advised once weekly self-calibration up to 3 months.

RESULTS:
Qmax improved from 7.0 to 25.6 ml/s and Post void Residual volume decreased from 200 to 15 ml. Operative time was 90min and Hospital stay was 3 days. Patient was Continent after surgery for follow up of 1 year.

DISCUSSION:
Female urethral stricture was treated in past with repeated urethral dilatations and internal urethrotomy. As in males, urethral stricture disease in females can cause voiding and storage lower urinary tract symptoms, recurrent urinary tract
infections, and even renal impairment. These symptoms are usually of long duration and severe which cause significant impairment in quality of life. Dorsal onlay Buccal Mucosal graft urethroplasty could be considered as an effective way to treat female urethral strictures.

**TITLE:**

“HEMI NEPHRO-URETERECTOMY FOR NON-FUNCTIONING UPPER POLE DUPLEX KIDNEY WITH URETEROVAGINAL FISTULA POST HYSTERECTOMY” - A RARE CASE REPORT

**AUTHORS:**

Dr. Sandeep Maheswara Reddy Kallam, Dr. Prakasa Rao Busam, Dr. Prabhakara Rao Medavankala

**INSTITUTE:**

Guntur Medical College & Government General Hospital, Guntur, Andhra Pradesh, India.

**INTRODUCTION:**

A 50-year-old female presented to urology outpatient department with continuous urinary incontinence after hysterectomy since 12 years. She had continuous urine leak per vagina day and night with normal voiding per urethra. Past history of abdominal hysterectomy for fibroid uterus 12 years ago. She was evaluated with Computerized Tomography Scan (CT-Urogram) showing left complete Duplex system with upper moiety thinned out parenchyma and grossly dilated Ureter till distal part, with opening into vagina. Left Duplex kidney lower moiety and opposite kidney was normal. Intra Venous Urography (IVU) shows non uptake of contrast of upper moiety and normal uptake and excretion of contrast in lower moiety and opposite kidney. Voiding Cysto-Urethrogram (VCUG) shows no Reflux. Isotope renal Scintigraphy (DTPA) scan shows non-functioning upper moiety. Cystoscopy done – Right Ureteric & Left lower moiety Ureteric orifices are identified. After performing Retrograde Bulb Ureterogram of left ureter showing lower moiety Ureter, Lt Double J (DJ) Stenting done for intra-op identification purpose and to avoid inadvertent injury to lower moiety ureter. Diagnosis of Iatrogenic Upper moiety Ureterovaginal Fistula with non-functioning upper moiety of Left Duplex Kidney was made. Patient was planned for Left Upper moiety Hemi Nephro-Ureterectomy. 2 separate incisions given - Upper Flank Incision & Lower Gibson Incision – Excision of upper moiety with
ureter till its insertion into vagina and vagina is closed. Intra-op & Post-op – Uneventful.

DISCUSSION:
Duplex ureters are have an estimated incidence of 0.8-1.8% and are more commonly found in women. Duplex systems are implicated in childhood urinary tract infections, hydronephrosis and parenchymal scarring but are often identified as incidental findings. The patient noted above had an undiagnosed double ureter system. Iatrogenic injuries are most common in the distal third of the ureter and are more likely to be detected intraoperatively in urological operations compared to other surgeries. Typically, as in this case, a ureteral injury is not noticed during the procedure and presents post-operatively. Injuries not recognized and repaired may progress to urinomas, hydronephrosis or ureteral fistulae. This Extremely rare case illustrates an often missed intraoperative injury and highlights the importance of awareness of anatomic anomalies during surgical procedures.

TITLE:
UM1 “HEMI NEPHRO-URETERECTOMY FOR NON-FUNCTIONING UPPER POLE DUPLEX KIDNEY WITH URETEROVAGINAL FISTULA POST HYSSTERECTOMY” - A RARE CASE REPORT

AUTHORS:
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INSTITUTE:
Guntur Medical College & Government General Hospital, Guntur, Andhra Pradesh, India.

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A 50 year old female presented to urology outpatient department with continuous urinary incontinence after hysterectomy since 12 years. She had continuous urine leak per vagina day and night with normal voiding per urethra. Past history of abdominal hysterectomy for fibroid uterus 12 years ago. She was evaluated with Computerized Tomography Scan (CT-Urogram) showing left complete
Duplex system with upper moiety thinned out parenchyma and grossly dilated Ureter till distal part, with opening into vagina. Left Duplex kidney lower moiety and opposite kidney was normal. Intra Venous Urography (IVU) shows non uptake of contrast of upper moiety and normal uptake and excretion of contrast in lower moiety and opposite kidney. Voiding Cysto-Urethrogram (VCUG) shows no Reflux. Isotope renal Scintigraphy (DTPA) scan shows non-functioning upper moiety. Cystoscopy done – Right Ureteric & Left lower moiety Ureteric orifices are identified. After performing Retrograde Bulb Ureterogram of left ureter showing lower moiety Ureter, Lt Double J (DJ) Stenting done for intra-op identification purpose and to avoid inadvertent injury to lower moiety ureter. Diagnosis of Iatrogenic Upper moiety Ureterovaginal Fistula with non-functioning upper moiety of Left Duplex Kidney was made. Patient was planned for Left Upper moiety Hemi Nephro-Ureterectomy. 2 separate incisions given - Upper Flank Incision & Lower Gibson Incision – Excision of upper moiety with ureter till its insertion in to vagina and vagina is closed. Intra-op & Post-op – Uneventful.

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Duplex ureters are have an estimated incidence of 0.8-1.8% and are more commonly found in women. Duplex systems are implicated in childhood urinary tract infections, hydronephrosis and parenchymal scarring but are often identified as incidental findings. The patient noted above had an undiagnosed double ureter system. Iatrogenic injuries are most common in the distal third of the ureter and are more likely to be detected intraoperatively in urological operations compared to other surgeries. Typically, as in this case, a ureteral injury is not noticed during the procedure and presents post-operatively. Injuries not recognized and repaired may progress to urinomas, hydronephrosis or ureteral fistulae. This Extremely rare case illustrates an often missed intraoperative injury and highlights the importance of awareness of anatomic anomalies during surgical procedures.

**UM2FEMALE URETHRAL LEIOMYOMA PRESENTING WITH ACUTE URINARY RETENTION –A RARE CASE WITH UNUSUAL PRESENTATION**

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Abstract
We present a case of urethral Leiomyoma of a female patient presenting with acute retention of urine. A 40 year old lady presented with a mass which was protruding from the urethral meatus causing urinary retention. Physical examination showed the presence of a mass protruding from the urethral meatus and filling the vaginal introitus. The patient was treated surgically and the symptoms completely resolved. Histopathological examination showed leiomyoma of the female urethra. A review of literature on the female urethra has revealed that the tumors of the female urethra presenting with acute urinary retention are very rare. Hence we report a case of leiomyoma of female distal urethra presenting with acute retention of urine.

Case Report

A 40 yrs old female patient presented with acute retention of urine to emergency department. On physical examination a 8-10cm ovoid mass, pink in colour, firm in consistency with areas of necrosis was seen protruding through urethral meatus and filling the vaginal introitus. MRI pelvis confirmed the origin of lesion as large exophytic mass hypointense on T1 weighted images and heterogenous signal intensity on T2 with heterogenous enhancement of contrast arising from posterior wall of urethra in its distal part.

She was operated, tumour excised and sent for histopathological examination and was reported as Leiomyoma of urethra.
INTRODUCTION

Bladder neck injuries are well known consequences of pelvic fracture related trauma to pelvic region and lower urinary tract. The risk of complete bladder neck injury is more common in children than in adults. Longitudinal split of bladder neck is more common in adults.

CASE HISTORY

58 year old male came with the history of Road Traffic Accident (RTA) with pelvic fractures leading to acute retention of urine for which suprapubic cystostomy (SPC) was done elsewhere 6 months back. Patient came to our centre for further management. Micturiting cystourethrography (MCU) was done which demonstrated old healed fractures of Right superior and inferior pubic rami, and significant narrowing at bladder neck with normal posterior and anterior urethra, and disruption. Flexible anterograde and retrograde cystoscopy was done in which contracted bladder neck with scarring and fibrosis was found. Flexible scope was not negotiable through the fibrosed bladder neck. Endoscopic resection of fibrotic scar was done with bladder neck incision at 3 and 9 “o” clock positions. 20 F per urethral Foley’s catheterization was done. On Post procedure Day 1, suprapubic catheter was removed and patient was discharged with Foley’s catheter in situ. On Post operative day 7, Foley’s catheter was removed and patient was voiding well.

DISCUSSION

Traumatic rupture of bladder neck and posterior urethra is usually associated with pelvic ring disruption. Bladder neck injuries are usually longitudinal which can extend into prostatic and sub-prostatic urethra. Transverse bladder neck injuries are common in children. The ultimate goal in these types of injuries is maintenance of continence, potency and a stricture free system.
Robotic surgeons have described techniques in urologic reconstruction. As the number of da vinci robots are increasing in number, more and more surgeons are doing more complex urological surgeries. We looked into the literature and our experience regarding outcomes and surgical steps for robotic pyeloplasty, robotic ureteral neocystostomy with ureteral reimplantation and robotic ureterolysis.

**METHODS**

We at our institute did more than 25 cases of reconstructive surgeries which include robotic pyeloplasty, reimplantation of ureter and uretero-ureterostomy. All these surgeries were done in adults. They all had good post surgical outcomes which was assessed by blood loss, time of the surgery, post op morbidity, no of inpatient days.

**RESULTS**

Outcomes reveal robotic assistance has greatly decreased the morbidity of urinary tract reconstruction, when compared with open surgical techniques. In addition, the superior visual and manual acuity of the robot allows one to perform surgical steps easier as compared with conventional laparoscopy.

**CONCLUSION**

Robotic assistance provides many benefits for urinary tract reconstruction.

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UM6. Poster presentation:
Endoscopic management of renal abscess: a case report
DR SHANTIVARDHAN KIMS HOSPITAL

**Introduction:**
Renal abscess has been managed by various treatments. Intravenous antibiotics, closed drainage using pigtails, open surgical management were the options used for effective management of renal abscess. We report our experience of endoscopic drainage of renal abscess.

**Care report:**
63 y old male patient, known case of type 2 DM, referred to our institute as a case of renal abscess post pigtail drainage. He was evaluated, imaging with CT scan done which showed another collection away from the first pigtail. Immediately second pigtail was inserted. But patient did not show signs of improvement as the pigtail was not draining due to thick viscous collection. He was not fit for anaesthesia due to his poor general condition. He was taken for
endoscopic drainage under low pressure and it was done under local anaesthesia. Loculated collection broken and pus drained out through 18 fr nephrostomy tube. Patient improved symptomatically and discharged in stable condition.

Conclusion:
Endoscopic drainage can be considered as a viable alternative to pig tail and open drainage under for renal abscesses in patients with poor general condition. With less invasive and local approach it seems to be an effective treatment for loculated renal abscesses.


Introduction:
Haematuria s one of the most common condition encounter in urology practice. Meticulous surgical plan and proper histopathological correlations defines the follow up management of the patient. Paraganglioma of urinary bladder is one of the rare causes of Haematuria. Relevant Biochemical investigations and regular follow up is essential in such cases.

Case report:
48 years old female presented with multiple episodes of painless Haematuria since one week. Radiological investigations suggestive of a small 2 x 2 cm mass in left lateral wall. With routine instigations are normal, patient underwent transurethral resurrection of bladder tumour with superficial and deep biopsy.

Initial reports suggestive of PEComa But final histopathological reporting came as urinary bladder paraganglioma. Due to no previous history of hypertension, it was diagnosed as non-functional paraganglioma. In view of histopathological report, post operatively, patients plasma Metanephines and urinary Vanillylmandelic acid was checked which were normal .CECT KUB suggested no residual tumour, invasion or evidence of metastasis. Regular three monthly follow up revealed no abnormal physical, biochemical findings or recurrence.

Conclusion:
Urinary bladder paraganglioma is a very rare cause of Haematuria and account for 0.06% of all bladder tumours and 6% of extra adrenal pheochromocytomas. This tumours arise from chromaffin tissue of sympathetic nervous system associated with the urinary bladder wall and maybe non-functional or functional.
They remain usually benign but may show malignant behaviour. Functional paraganglioma may cause hypertensive crisis provoked by micturition defaecation, overdistention of the bladder or bladder instrumentation. MIBG scan is diagnostic. Surgical resection is the treatment of choice after biochemical control.

UNMODERATED POSTER PRIZE SESSION

UM9. REDO PARTIAL NEPHRECTOMY FOR RECURRENT AML – A CASE REPORT


*Department Of Urology and Renal Transplantation, Narayana Medical College, Nellore, Andhra Pradesh*

**Introduction** - Angiomyolipomas (AMls) are common benign renal tumor representing 0.3% of all renal tumors. It is associated with Tuberous Sclerosis Complex (TSC) in 20% of patients. Local recurrence after nephron sparing surgery is seen in 3-4% of cases. The greater utilization of partial nephrectomy and ablative procedures has increased the incidence of patients presenting with local renal recurrence. The choice to either perform a partial or radical nephrectomy in these situations can be a challenging decision.

**Aims and Objective:** We report a case of redo partial nephrectomy for B/l AML who underwent left open partial nephrectomy 6 yrs back.

**Methods** - 29 Years Female, with H/o Emergency laprotomy 6 yrs back for AML Haemorrhage, underwent Left open Partial nephrectomy presented with left loin pain and haematuria, found to have recurrent AML. CECT abdomen revealed Bilateral AML, multiple AML lesions largest measuring 4.4 x 4.5 cm in left lower pole and 1.4 x 1.3 cm in Right mid pole of kidney. Patient underwent Left open partial nephrectomy. Post operatively patient had urine leak in drain, subsided with conservative management. HPE confirming AML of size 5 x 4 cm. At 6 months follow up patient is doing well.

**Conclusion:** Repeat partial nephrectomy in selective cases is feasible option especially in the management of patients at risk for the development of multiple bilateral synchronous or metachronous AML.
UM10. PARTIAL NEPHRECTOMY FOR GIANT ANGIOMYOLIPOMA WITH OUT ARTERIAL EMBOLIZATION – A CASE REPORT


Department Of Urology and Renal Transplantation, Narayana Medical College, Nellore, Andhra Pradesh

Introduction - Renal angiomyolipoma (AML), also referred to as renal hamartoma, is a rare benign neoplasm, typically composed of varying admixtures of blood vessels, smooth muscle cells, and adipose tissue. The inheritance pattern of renal AML is autosomal dominant. There are only few cases of giant renal AML (>20 cm) reported in the literature.

Aims and Objective: We report a case of giant angiomyolipoma managed with laparoscopic-assisted partial nephrectomy.

Methods and results:

37-year-old male patient, who presented with right-sided abdominal pain of 2 months duration. O/E palpable lump in Rt lumbar region. CECT Abdomen revealing large well-defined ovoid heterogeneously hypodense (45 HU) in Rt hypochondrium and Rt lumbar region, lesion displacing IVC, kidney and bowel antero-medially. The patient underwent lap-assisted Right partial nephrectomy. The resected mass was sized 25×20×10 cm. Postoperative stay was uneventful. Histopathological examination confirmed the lesion as a giant renal AML.

Conclusion: Management of giant AMLs is challenging, and even for large tumors, partial nephrectomy remains a viable option that should be considered.

UNMODERATED POSTER PRIZE SESSION

UM11. LAPROSCOPIC RIGHT ADRENALECTOMY FOR GIANT PHEOCHROMOCYTOMA – A CASE REPORT

Department Of Urology and Renal Transplantation, Narayana Medical College, Nellore, Andhra Pradesh

Introduction - Pheochromocytoma (PCC) is a catecholamine-secreting tumour from chromaffin cells of the embryonic neural crest. It has an estimated incidence of 0.1% in the general population. Giant pheochromocytomas (> 10 cm in size) are rare entities with few cases reported in the literature. Most giant pheochromocytomas do not present with classic symptoms.

Aims and Objective: We report a case of Giant pheochromocytoma managed with laproscopic right adrenalectomy.

Methods and results

A 31-year, female patient, who presented with right loin pain for ~2 months, O/E palpable lump in Right lumbar region. CECT abdomen showed oval heterogeneous soft tissue density enhancing mass in Right adrenal region. 24 hr urinary metanephrines were 109.41 (Ref range <350). Right laproscopic adrenalectomy was performed. The resected mass was sized 10×8.7×8.5 cm. Post operative stay was uneventful. Histopathological examination confirmed the lesion as Pheochromocytoma with PASS score 6.

Conclusion: Management of giant pheochromocytoma is ultimately patient-centric and tailored on a case-by-case basis, and even for large tumors, laproscopic adrenalectomy remains a viable option that should be considered.

UNMODERATED POSTER PRIZE SESSION

UM12. CONGENITAL SCAPHOID MEGALOURETHRA: A CASE REPORT


Introduction - Congenital megalourethra is a rare congenital anomaly of the male anterior urethra and erectile tissue of penis. The scaphoid type is caused by poor development of corpus spongiosum. In the more severe fusiform type is a deficiency of the corpus cavernosum, as well as the corpus spongiosum. Megalourethra is often associated with other congenital anomalies of which genitourinary are most common.
Aims and Objective: We report a case of congenital scaphoid megalourethra with spina bifida and crossed fused ectopia

Methods - 5 years boy presented with c/o ballooning of prepuce while micturating since birth. H/o LSCS, low birth weight, O/E meatus adequate, Genitalia Normal, fleshy urethra palpable. CT Plain KUB showed crossed fused ectopia with Right HDUN, Spina bifida at D11 vertebrae. DTPA showed moderate parenchymal dysfunction of lower moiety with normal upper moiety. MCU shows dilated bulbar urethra and absence of reflex and normal bladder

Results: Reduction urethroplasty was done for child. After degloving the scaphoid dilatation was noted. The redundant urethra with deficient corpus spongiosum was excised and the urethra was reconstructed over 8 Fr infant feeding tube urethral catheter was removed after 10 days and at 3 months follow up patient voiding normally without any penile swelling.

Conclusion: Scaphoid type of megalourethra, reduction urethroplasty provides excellent functional and cosmetic results.