THE SOUTHSIDE OF UROLOGY 2022

2º SIMPÓSIO DE UROLOGIA

04 e 05 | novembro | 2022

Hotel Tryp Lisboa Caparica Mar
Costa da Caparica

Design: Ad Médic

SCIENTIFIC PROGRAM

Digital version of the program with abstracts

THE SOUTHSIDE OF UROLOGY 2022

2º SIMPÓSIO DE UROLOGIA

04 DE NOVEMBRO DE 2022 | SEXTA-FEIRA

08:00h	Abertura do Secretariado
08:45-09:00h	**Sessão de Abertura** Diretor do Serviço de Urologia do HGO, EPE Diretor Clínico HGO, EPE Presidente do Conselho de Administração do HGO, EPE Presidente do Conselho Clínico e de Saúde ACES Almada Seixal Presidente do Colégio de Urologia da Ordem dos Médicos Presidente da Associação Portuguesa de Urologia
09:00-10:30h	**CARCINOMA RENAL – CONTROVÉRSIAS OU CERTEZAS?** Moderadores: Nuno Figueira, Pedro Nunes e Eduardo Silva
09:00-09:15h	***Screen* genético – Quando?** Gil Falcão
09:15-09:30h	**Pequena massa renal – Vigilância e terapêutica ablativa. Quando e como?** Lorenzo Marconi
09:30-09:45h	**Tumor localmente avançado com trombo na v. cava nível III/IV** Tito Leitão
09:45-10:00h	**O futuro da nefrectomia citoredutora no CCR avançado na era da imunoterapia** Belmiro Parada
10:00-10:20h	**Conferência** **A FORMAÇÃO EM CIRURGIA ABERTA DOS JOVENS UROLOGISTAS AINDA TEM LUGAR NA ERA DA CIRURGIA ROBÓTICA?** Kris Maes
10:20-10:30h	**Discussão**
10:30-11:00h	Pausa para café e visita aos posters

11:00-12:30h **CARCINOMA UROTELIAL**
Moderadores: João Paulo Rosa, Carlos Rabaça e Tiago Lopes

11:00-11:15h **Devemos expandir os critérios para cirurgia poupadora de nefrónios no carcinoma urotelial do alto aparelho urinário?**
Rodrigo Ramos

11:15-11:30h **O nariz eletrónico no carcinoma urotelial da bexiga**
Projeto ENSURE – FCT/NOVA e Urologia HGO
Susana Palma

11:30-11:45h **Carcinoma da bexiga T2N0M0 – Cistectomia?**
Andrea Furtado

11:45-12:00h **Carcinoma da bexiga T2N0M0 – Tratamento trimodal?**
Paulo Jorge Dinis

12:00-12:20h **Conferência**
CISTECTOMIA RADICAL – ESTADO DA ARTE
Estevão Lima

12:20-12:30h **Discussão**

12:30-13:00h ***Industry Symposium***
Bristol Myers Squibb
NOVIDADES NO TRATAMENTO DE 1ª LINHA DOS DOENTES COM CARCINOMA DAS CÉLULAS RENAIS. DADOS A LONGO PRAZO

12:30-12:35h **Introdução & abertura**
Helder Mansinho e Miguel Carvalho

Uma conversa sobre:

12:35-12:45h **Qual o quadro clínico dos doentes de cancro renal que nos chegam à Urologia?**
Miguel Carvalho

12:45-12:55h **O conceito IO/IO no tratamento de 1ª Linha dos doentes com carcinoma das células renais. Dados a longo prazo**
Helder Mansinho

12:55-13:00h **Discussão & fecho**
Miguel Carvalho e Helder Mansinho

13:00-14:30h Almoço e visita aos posters

14:30-16:00h **CARCINOMA UROTELIAL**
Moderadores: Nuno Fidalgo, Luís Campos Pinheiro e Belmiro Parada

14:30-14:45h **RMN no carcinoma urotelial da bexiga – O que há de novo?**
João Costa

14:45-15:00h **Carcinoma urotelial da bexiga pTa de alto grau. Devemos simplificar ou estratificar o risco?**
Alexandre Macedo

15:00-15:15h **re-RTU no carcinoma urotelial da bexiga – Quem dita a lei? A biologia do tumor ou a experiência do cirurgião?**
Andre Barcelos

15:15-15:30h **Carcinoma urotelial da bexiga não músculo-invasivo refratário ao BCG. Cistectomia? Imunoterapia sistémica? Terapêutica intravesical?**
Francisco Fernandes

15:30-15:50h **Conferência**
BIOMARCADORES NO DIAGNÓSTICO, PROGNÓSTICO, MONITORIZAÇÃO E TRATAMENTO DO CANCRO DA BEXIGA
Pedro Nunes

15:50-16:00h **Discussão**

16:00-16:30h Pausa para café e visita aos posters

16:30-17:30h **CARCINOMA DA PRÓSTATA**
Moderadores: Palma dos Reis, Paulo Vale e Anibal Coutinho

16:30-16:45h **Na era da genética a história familiar não é suficiente. Quem e quando referenciar?**
Carolina Ponte

16:45-17:00h **A inteligência artificial no diagnóstico – Moda ou realidade?**
Pedro Bargão

17:00-17:15h **RMN biparamétrica – Prontos para a mudança?**
Miguel Ramalho

17:15-17:30h **Discussão**

17:30-18:00h ***Industry Symposium***
MELHORAR OS RESULTADOS NO CPRCNM: TRATAR OU NÃO TRATAR? ESSA NÃO É A QUESTÃO
IMPROVING CPRCNM OUTCOMES: TO TREAT OR NOT TO TREAT? THAT'S NOT THE POINT
Moderadores: Miguel Carvalho e Avelino Fraga
Rodrigo Ramos

18:00h Encerramento do primeiro dia do Simpósio

THE SOUTHSIDE OF UROLOGY 2022

2º SIMPÓSIO DE UROLOGIA

05 DE NOVEMBRO DE 2022 | SÁBADO

08:00h	Abertura do Secretariado
08:30-09:15h	**Apresentação dos 3 posters selecionados e vídeos** Moderadores: João Varregoso e Gustavo Gomes
09:15-10:45h	**CARCINOMA DA PRÓSTATA** Moderadores: Avelino Fraga, Carlos Silva e Miguel Ramos
09:15-09:30h	**Biópsia transperineal guiada por imagem de RMN – O novo *gold-standard*?** João Pina
09:30-09:45h	**Será benéfico o estadiamento inicial com PET-PSMA nos doentes de alto risco?** Rita Teixeira Ferreira
09:45-10:00h	**O papel atual da RMN na vigilância ativa** Sónia Palma
10:00-10:15h	**Prostatectomia radical robótica no SNS – O futuro é uma miragem?** Luís Campos Pinheiro
10:15-10:35h	**Conferência** **IMPLEMENTAÇÃO DE MEDIDAS PROM (*PATIENT RELATED OUTCOMES*) NA ABORDAGEM DOS DOENTES COM DOENÇA LOCALIZADA** Catarina Carvalho
10:35-10:45h	**Discussão**
10:45-11:15h	Pausa para café

11:15-12:50h **CARCINOMA DA PRÓSTATA**
Moderadores: Jorge Fonseca, Amaral Canelas
e Luis Miguel Abranches Monteiro

11:15-11:30h **Ir para além da clínica. Quando a biologia molecular ajuda...**
Ricardo Leão

11:30-11:45h **Cirurgia no carcinoma da próstata oligometastático**
Luisa Alves

11:45-12:00h **Sequenciação terapêutica no mCPRC**
André Mansinho

12:00-12:15h **PSMA – Lutécio: Para onde nos leva o caminho?**
Ana Isabel Santos

12:15-12:30h **Discussão**

12:30-12:50h **Conferência**
HGO, PERSPETIVAS DE INTEGRAÇÃO NO CENTRO CLÍNICO ACADÉMICO DO ALGARVE
Paula Breia

12:50-13:00h **Sessão de encerramento do *The Southside of Urology* 2022**
Moderador: Miguel Carvalho
Painel: João Paulo Rosa, Nuno Fidalgo de Oliveira, Nuno Figueira, Alexandre Macedo, Margarida André e Luísa Moreira

VIDEOS

V 01

LAPAROSCOPIC RIGHT NEPHRECTOMY FOR MASSIVELY HYDRONEPHROTIC KIDNEY

Bárbara Oliveira[1]; Gilberto Rosa[1]; Pedro Barros[1]; Aníbal Coutinho[1]
[1]Centro Hospitalar do Algarve, EPE / Hospital de Faro

Introduction: Laparoscopic nephrectomy may be complicated by peripheral adhesions developing secondary to previous episodes of pyelonephrosis. In addition to JUP obstructions, one of the most important factors in the developement of hydronephrotic kidney is longstanding renal stones that may lead to hydronephrosis and non-functioning kidneys
Goals: The aim is to report laparoscopic nephrectomy for large non-functioning kidney
Methods: Pre-operative renal US, CT and renal scintigraphy with DSMA were performed to establish diagnose. The patients' data, presentation, investigations pre-and post-operative were collected from the clinical file
Results: A 66years male with a history of Erythrocytosis Renal lithiasis, CKD, Arterial Hypertension, Hyperuricemia, Glaucoma, Dyslipidemia, Moderate S. Central Sleep Apnea. Ex-smoker. Contact with unprotected inks
Medicated with Allopurinol, Uralyt-U, AAS, Pitavastatin, Monoprost, Indapamide
He was referred for recurrent low back pain and a visible abdominal mass with bulging of the right flank. Patient had two hospitalizations in 2006 for right pyelonephritis and months after for open ureterotomy with midline incision. CT showned massive right hydronephrosis (222mm) with minimal remaining renal parenchyma with filiform right renal artery with a length of 9 mm. Vena Cava and Aorta are displaced as kidney extends beyond midline. Left kidney with preserved parenchyma with no lithiasic focus. Scintigraphy showed functional absence of the right kidney.
Under general anaesthesia, patient were positioned in the modified flank position. Entry was made from the paraumbilical region with Hasson technique,and pneumoperitoneum was created The other two trocars were placed under direct vision. A 5 mm port was inserted close to the midline . a incision was made between the Toldt line and the colonic flexure. The gerota fascia was incised and subsequently, dissection followed until the renal pelvis.The renal artery and vein were reached and clipped with Hem-o-lock clips,the ureter was cut. The dissection of the upper pole was difficult due to lack of space and hepatic adhesions and it was decided to drain it with an outlet of 690cc of purulent content. Hemostasis control (6 mmHg). The excised kidney was removed within an endo-bag, without opening the skin incision with

removal of the kidney in fragments by the 12 mm trocar

Discussion/Conclusions: Drain was removed and the patient was discharged on the 3rd day post-op.

Pathological study: Parenchymal atrophy with fibrosis, glomerular sclerosis and mild mononuclear inflammatory infiltrate associated with dilation of the pyelocaliceal tree, in context of hydronephrosis. Absence of malignant neoplasm

This surgery may become even more difficult due to limited space and potentially dense adhesions around the kidney, particularly in patients with hydronephrotic kidneys as opposed to patients with small kidneys.

V 02

LAPAROSCOPIC PYELOURETEROLITHOTOMY – TREATMENT OF RECURRENT GIANT URETERAL CALCULI

Margarida André[1]; Alexandre Macedo[1]; Nuno Fidalgo[1]; João Paulo Rosa[1]
[1]Hospital Garcia de Orta, EPE

Introduction: Urolithiasis is of high prevalence in clinical practice. Recurrent urolithiasis constitutes a challenge for the Urologist.

Case report: We present the case of a 53-year-old male patient, with prior history of urolithiasis, who had already been submitted to endoscopic treatment in three different moments, medical treatment after metabolic study and a laparoscopic left pyeloureterolithotomy, with extraction of 3 stones, with the post-operative computed tomography showing a stone free kidney and ureter. Six months after the last surgery, he had a bilateral obstructive pyelonephritis, with the abdomino-pelvic computed tomography revealing three stones in the proximal left ureter of 13, 14 and 21 mm and a 8 mm stone in the lumbar right ureter. Bilateral double J stents were placed. Three months later he underwent a new laparoscopic left pyeloureterolithotomy, that we present on this video. The patient was placed in right lateral decubitus. Four trocars were placed (2 of 12 mm and 2 of 5 mm). The first step was the identification of the kidney. Inflammatory changes were identified in the peripyelic and periureteral zone, consistent with previous surgery and the recent pyelonephritis. Then the pyeloureteral junction was approached, where the bigger stone was placed. The three stones were extracted intact, and sent for biochemical analysis. The double J stent, which was calcified, was also extracted. A new double J stent was placed anterogradely. The pyeloureteral junction was closed with a running suture of a 3/0 absorbable suture (Vycril®). An aspirative drain was placed. Surgical time: 130 minutes. Blood loss: 50 mL. The post operative period was uneventful, with the vesical catheterization being removed on the first day and the drain on the third. An abdomino-pelvic computed tomography was performed after one month, revealing a stone free kidney and ureter on the left side. The stent was extracted at the sixth postoperative week.

Conclusion: Our case demonstrates that despite the various developments in endoscopic technologies, there is an important role for laparoscopic and even open surgery for the management of giant ureteric stones in order to achieve the best results and a stone free patient.

POSTERS

PO 01

MANAGEMENT OF IATROGENIC URETERAL INJURY: BILATERAL URETERAL REIMPLANTATION WITH A BOARI FLAP

Bárbara Oliveira[1]; Pedro Barros[1]; Vera Ribeiro[1]; Gilberto Rosa[1]; Aníbal Coutinho[1]
[1]Centro Hospitalar do Algarve, EPE / Hospital de Faro

Introduction & objectives: There are different causes of iatrogenic ureteral injury; during hysterectomy, the lesion is more frequently distal where the ureter passes below the uterine vessels,its production mechanisms are ligation or ureteral entrapment by stitching section or avulsion, partial section and ureteral devascularization.

We aimed to report the bilateral feasibility of the Boari flap within a bilateral iatrogenic ureteral injury

Materials & methods: Consultation of the patient's file and scientific literature review

Results: A 52 years old female patient was referred as a case of post radical hysterectomy with bilateral pelvic lymphadenectomy 4 months ago due to endocervical adenocarcinoma pT1B1pN0,with increased abdominal volume suggestive of ascites, decreased urinary output with no pain or other symptoms. The laboratory tests only changes were BUN>125 mg/dL and Cr 12,2 mg/dL.A bladder catheter was placed with no urine output. CT indicated abundant amount of intra-abdominal fluid with bilateral hydronephrosis without evidence of an obstructive cause and no evidence of recurrence or metastatic disease(Fig1A).After that a paracentesis was performed with drainage of 4.5L of citrine liquid.

Nephrostomies were placed with the nephrostography showing a stop image at terminal ureter bilaterally and cystography without contrast extravasation.

After that, the patient showed clinical and analytical improvement with abundant clear urine output with normalization of renal function within 72 hours.

The patient was admitted for laparoscopic ureteral reimplantation, significant adhesions and phlegmon holding the bladder and distal ureters with sigmoid was evident, right ureter had reached the left side. Since the dissection was difficult,we shifted to open surgery. The attempt for the mobilization of the bladder was unsuccessful so Boari flap with Psoas Hitch was used and finally, the anti-reflux mechanism according to politano leadbetter technique(fig2).The ureters was catheterized with a double J,drainage as well as Foley catheter .The postoperative period was uneventful, with discharge home on the fifth day. At 4 weeks, the double J catheter without showing hydronephrosis or other signs of complications.

10 months post-surgical follow-up TC indica-

ted only a slight reflux on the left ureter with patency of both ureters,no contrast leak, she remains asymptomatic, with normal renal function.

Conclusions: Ureteral injuries are mostly iatrogenic and their diagnosis is as much a clinical challenge as reconstruction is a surgical challenge.Management is based on the timing of diagnosis, the etiology, the length and location of the injury, the patient's overall status, and other associated injuries. It ranges from an excellent reconstruction to a more conservative approach. The precise nature of the injury should be defined to decide the best method of repair.

PO 02

SINGLE CENTRE ANALYSIS OF I-125 LDR BRACHYTHERAPY IN EARLY PROSTATE CANCER – PRELIMINARY RESULTS

Teresa Bértolo Rosa[1]; Catarina Tranvancinha[2]; Maria Fortunato[1]; Claúdia Viveiros[3]; Telma Antunes[4]; Eduardo Silva[1]; Celso Marialva[1]; Pedro Silva[5]; Liliana Carita[1]; Filomena Santos[1]

[1]IPO Lisboa; [2]Hospital Cuf Descobertas; [3]Centro Hospitalar Barreiro/Montijo, EPE / Hospital Nossa Senhora do Rosário; [4]Hospital da Luz Lisboa; [5]Centro Hospitalar de Lisboa Norte, EPE / Hospital de Santa Maria

Introduction: Prostate cancer is one of the most frequently diagnosed cancers in the developed world. Brachytherapy is a valid treatment option for nonmetastatic prostate cancer as local tumour control is associated with improved outcomes in patients with organ-confined prostate cancer (even in the presence of high-risk features).

Goals: Evaluate the biochemical failure and toxicity outcomes in patients with early prostate cancer who underwent curative monotherapy treatment with I-125 LDR Brachytherapy (I-125 BT).

Methods: Retrospective analysis of patients with prostatic ADC treated with I-125 BT with a total dose of 145Gy, in a single institution from 2011 to 2019.

The patients were stratified into risk groups according to the National Comprehensive Cancer Network (NCCN) guidelines. Biochemical recurrence was defined according to Phoenix definition (nadir + 2ng/mL).

Genitourinary (GU), Gastrointestinal (GI) and Sexual (S) toxicities were retrospectively assessed by applying the Common Terminology Criteria for Adverse Events (CTCAE v5.0).

Results: We report a single-institutional experience in outcomes analysis with the use of I-125 LDR Brachytherapy for the primary management of early-stage prostate cancer.

Two hundred and five consecutive patients with prostatic adenocarcinoma were treated at a single institution using I-125 LDR Brachytherapy with curative intent. Ten were lost for follow-up, thus were analysed one hundred ninety-five patients. One hundred eighty-three (94%) patients were classified as low-risk, and eleven (6%) as intermediate-favourable risk. The dose prescription was 145 Gy to the planning target volume. Only fourteen (7,2%) patients received androgen deprivation therapy (ADT) with the intent of organ volume reduction, for a median 3 months (1 a 9 months), starting up to 9 months prior to I-125 BT.

GU toxicity was by far the most frequent acute toxicity, occurring in 77% of all patients: CTCAE grade 1 present in 56%, grade 2 in 21%, and grade 3 in 0,5%. Acute GI and S toxicities occurred in 8,2% and 25,6%, respectively.

Late GU toxicity was present in 81% of cases: CTCAE grade 1 present in 63%, grade 2 in 17%, grade 3 in 1%. Late GI toxicity occurred in 18% of cases while late S toxicity in 42%.

With median follow-up (FU) of 36,5 months (0,5 to 5,5 years), the 3 year-biochemical disease-free survival was 96%. The most common toxicity at FU was GU which was present in 46% of cases, followed by S in 20%, and

GI in 4%. Approximately, 30% of cases were asymptomatic.
In a total of 195 cases, there were only 7 biochemical recurrences, all of which occurred 18 to 25 months after I-125 BT and without macroscopic recurrence identified.
Conclusion: Patients treated with I-125 BT for early prostate cancer have excellent rates of biochemical control and low rates of severe toxicity of treatment.

PO 03
O OVO DE COLOMBO

Guilherme Bernardo
Hospital Prof. Doutor Fernando Fonseca

Doente de 54 anos, com AP de LUTS de armazenamento, sem outros antecedentes. Recorreu ao médico de família por dor na anca à direita, tendo realizado RX da bacia, que revelou uma imagem calcificada na pélvis. Realizou TC pélvico, que revelou "loca com calcificação parietal, bem delimitada e homogénea, com densidade heterogénea mas sem aumento da densidade após administração de contraste, condicionando moldagem da parede lateral esquerda da bexiga, situando-se entre esta e os vasos ilíacosd, sendo contornada atrás pelo ureter esquerdo, acima da próstata e à frente das vesículas seminais. Foi submetido a excisão da massa por via laparoscópica, que revelou uma lesão "antiga, com fibrose, calcificação e trombos associados, sem especificidade etiológica, sem tecido de neoplasia ou microsganismos". O caso foi discutido em reunião multidisciplinar de anatomia patológica, tendo sido discutidas as hipóteses diagnósticas mais prováveis para justificar o aparecimento deste "Ovo de Colombo"

PO 04
A IMPORTÂNCIA DA FLUORESCÊNCIA NA UROLOGIA

Guilherme Bernardo
Hospital Prof. Doutor Fernando Fonseca

Caso de um doente de 63 anos, masculino, com antecedentes de Nefrectomia radical direita laparoscópica por CCR em 2016, G2, pT1A com aparecimento de metástase peri-hilar e da supra-renal esquerda de carcinoma de células renais. Por via aberta, utilizando fluorescência, foi possível a identificação do tecido de neoplasia e a realização de tumorectomia com 8x6x2,5 cm, que incluia a glândula suprarenal e dois nódulos no tedido adiposo peri-adrenal. O diagnóstico histológico confirmou a peça como sendo metástases de carcinoma de células renais, variante de células claras, morfologicamente semelhantes ao exame da peça de nefrectomia

PO 05
1º TEMPO DE JOHANSON – UM ESTUDO DE CASO

Guilherme Bernardo
Hospital Prof. Doutor Fernando Fonseca

Caso clínico de doente de 54 anos, antecedentes pessoais de hipertensão arterial, sem antecedentes urológicos conhecidos. Recorre ao serviço de urgência por disúria e tumefacção dos genitais externos, com dois dias de evolução, acompanhada por febre e mal.estar geral. A TC revelou uma suspeiita de fasceíte necrotizante, tendo sido colocado cistocatéter e realizado desbridamento cirúrgico no bloco operatório. Constatou-se, intra-operatoriamente, a presença de uma solução de descontinuidade com cerca de 2 cm no prato posterior da uretra bulbar, confirmando-se um urinoma por infiltração por urina das túnicas escrotais. Realizados cuidados de penso, e posteriormente o primeiro tempo de Johanson, com reconstrução parcial da uretra, em colaboração com a cirurgia plástica.

PO 06

UM CASO DE URETERÓLISE NO CONTEXTO DE FIBROSE RETROPERITONEAL

Guilherme Bernardo
Hospital Prof. Doutor Fernando Fonseca

Caso de uma doente do sexo feminino, de 67 anos, com o diagnóstico de fibrose retroperitoneal idiopática a condicionar ureterohidronefrose bilateral, status pós infecção grave por COVID-19 com sobreinfecção bacteriana e necessidade de internamento em UCI. Cumpriu programa de reabilitação em Alcoitão. Necessidade de nefrostomias e stents JJ bilaterais, com substituição regular. Realizada Ureterólise bilateral. Com o apoio da cirurgia geral, foi possível realizar um isolemtnto do grande epíploon, com confecção de dois retalhos verticais que se fizeram passar por janelas nos mesocolons direito e esquerdo. Foram posteriormente fixados aos músculos psoas e ao ureter, constituindo-se, assim, um leito de epíploon para os ureteres bilateralmente. A doente já retirou os stents JJ colocados aquando da cirurgia, estando atualmente assintomática.

PO 07

OXIGENOTERAPIA HIPERBÁRICA NO TRATAMENTO DAS INFEÇÕES NECROTIZANTES DA PELE E TECIDOS MOLES,

Guilherme Bernardo
Hospital Prof. Doutor Fernando Fonseca

A infecção necrotizante dos tecidos moles é uma infeção rara e grave que se caracteriza pela necrose progressiva da fáscia, músculo, tecido subcutâneo e pele. Comeste trabalho pretende-se objectivar o papel da Oxigenoterapia Hiperbárica (OHB) no tratamento destas infecções. Trata-se de um estudo retrospectivo, descritivo, tendo sido feita uma revisão dos processos dos doente se tratados com OHB no período entre Dezembro de 1989 e Dezembro de 2020 no CMSH com o diagnóstico de infecção necrotizante dos tecidos moles. Foram analisados os seguintes parâmetros: caracterização da população, etiologia, comorbilidades, desbridamento cirúrgico com medidas mais agressivas (amputação, derivação do trânsito intestinal ou orquidectomia),antibioterapia utilizada, internamento em UCI, necessidade de ventilação invasiva, necessidade de TSR e mortalidade a um ano. Verificou-se que a taxa de mortalidade nesta série foi de 12%, o que vai de encontro às taxas reportadas em estudos mais recentes, nomeadamente em estudos sobre a utilização da OHB nas infeções necrotizantes dos tecidos moles Comparando com valores de mortalidade que rondam os 25-35%,verificou-se uma franca tendência positiva na taxa de sobrevivência. Esta tendência deve-se a uma considerável melhoria dos cuidados médicos prestados a estes doentes Nesta série,à semelhança de outros estudos,a diabetes foi a principal comorbilidade encontrada, sugerindo que a diabetes seja um dos principais fatores predisponentes.

PO 08

THERAPEUTIC APPROACH TO SEXUAL DYSFUNCTION IN PATIENTS WITH UROLOGIC CANCERS

Mariana Dias Capinha[1]; Carlos Oliveira[1]; Sara Anacleto[1]; Ricardo Matos[1]; Catarina Tinoco[1]; Andreia Cardoso[1]; Ana Sofia Araújo[1]; Emanuel Dias[1]; Mário Cerqueira Alves[1]
[1]*Hospital de Braga*

Introduction: Sexual dysfunction is characterized by the disruption of one or more elements of the human sexual response cycle. Both sexes can be affected by urological neoplasms. In males, sexual dysfunction may be secondary to the treatment of prostate, testis, penis or bladder cancer. In females, bladder cancer is largely responsible for sexual dysfunction in urological neoplasms. Its thera-

peutic approach is still an unmet need.

Goals: The present work aims to present a literature review on the topic: Therapeutic approach to sexual dysfunction in patients with urologic cancers.

Material and methods: The literature review was performed in Pubmed, Cochrane and Embase databases with the following terms: ((sexual dysfunction) AND (cancer)) AND (treatment). The following filters were applied: Meta-Analysis, Randomized Controlled Trial, Review, and Systematic Review in the last five years. The search resulted in seventy-eight publications. Thirty articles were selected.

Results: The work presents therapeutic approaches that can be used in sexual dysfunction in both sexes. In males, for penile rehabilitation, there are several therapeutic approaches such as 5-phosphodiesterase inhibitors, vacuum erectile device therapy, intracavernous injections, topical/intraurethral alprostadil, penile prosthesis, among other new therapeutic approaches. However, other complications may need intervention such as anorgasmia, dysosgarmia, climaturia, and penile deformity. Concerning females, bladder cancer can have a negative impact on the sexual function of patients. To mention decreased libido, decreased vaginal lubrication, dyspareunia, and orgasmic dysfunction. There are numerous possible interventions to minimize these effects such as psychosocial interventions, vulvar moisturizers, topical estrogens, intravaginal dehydroepiandrosterone, vaginal dilators, vibrators, pelvic floor physiotherapy, neovaginas and pharmacological treatment (testosterone supplementation and 5-phosphodiesterase inhibitors). It is also important to have biopsychosocial support programs that allow a holistic approach to the patient.

Discussion/Conclusions: Although sexual health issues are a major concern for patients, they often find it difficult to share their grievances with healthcare professionals or their partners. From a clinician's perspective, wrong assumptions, lack of time and lack of training on sexual health leads to issues on this topic being undervalued. This review highlights the currently available treatment options for sexual dysfunction in cancer patients however, the results are based on non-standardized methods to assess sexual function, heterogeneous studies, and low evidence. Thus, it is necessary to standardize the methods to characterize sexual dysfunction and subsequently advance with studies for its treatment.

PO 09

PARANEOPLASTIC SYNDROMES IN RENAL CELL CARCINOMA – RARE CASE OF DERMATOMYOSITIS TREATED BY UROLOGIST

Alexandre Macedo[1]; Margarida André[1]; Luisa Moreira[1]; Nuno Figueira[1]; Miguel Carvalho[1]
[1]*Hospital Garcia de Orta, EPE*

Introduction: Renal cell carcinoma (RCC) is unique among the genitourinary malignancies in that up to 40% of affected patients show a paraneoplastic syndrome that is defined as a constellation of systemic signs and symptoms that are secondary to the presence of a malignancy. By definition these syndromes exclude the sequelae of either direct tumor extension or metastasis. These tumor-related syndromes may be the result of one of several factors: tumor production of humoral substances, or benign tissue production of humoral factors in response to renal malignancy or via the modulation of the immune system. The importance of understanding these paraneoplastic symptoms lies in the fact that they may be the initial manifestation of either primary or recurrent disease.

Goals: This review will provide information on many paraneoplastic syndromes associated with RCC (prevalence, proposed mechanisms

of action, clinical assessment and treatment options); as an example of a rare variant, an atypical case of paraneoplastic dermatomyositis treated with radical nephrectomy is also reported.

Methods: A MEDLINE search for "paraneoplastic syndrome", "renal cell carcinoma", "renal cancer" and "dermatomyositis" was performed and information was selected to make a review. An atypical case of dermatomyositis associated with RCC was reported based on clinical data records of our Institution.

Results: A 35-year-old female developed severe muscle weakness. Heliotrope rash, Gottron's papules, blood results and electromyography suggested a diagnosis of dermatomyositis. A computed tomography of the chest, abdomen and pelvis showed a solid mass in the left kidney. She underwent a left laparoscopic radical nephrectomy and histology confirmed renal cell carcinoma (clear cell subtype). After 3 months, dermatomyositis manifestations completely disappeared and the patient stopped corticotherapy. She remains asymptomatic during follow-up in Urology consultation.

Discussion/Conclusions: RCC was previously referred to as the internist's tumor because of the predominance of systemic rather than local manifestations. Most paraneoplastic syndromes associated with localized RCC are only definitively treated with nephrectomy. The reported case illustrates the potential role of nephrectomy in cases of dermatomyositis induced by renal cell carcinoma as there was no improvement with medical therapy prior to surgery. Only 5 cases of dermatomyositis associated with RCC were published. The recurrence of a previous paraneoplastic syndrome should alert the physician to possible disease progression.

PO 10

OPEN PYELOLITHOTOMY AND CYSTOLITHOTOMY IN A CASE OF A FORGOTTEN DOUBLE J STENT – HOW OLDFASHIONED

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Introduction: Double J ureteral stents have a major importance in the treatment of upper urinary tract obstruction. However, delay in removing them is associated with a higher probability of calcification, possibly resulting in staghorn kidney stones and intravesical stones. There are several approaches to the removal of a calcified stent: extracorporeal lithotripsy, endoscopic lithotripsy, laparoscopic or open surgery. Due to the advances in endourology and minimally invasive surgery, open surgery is nowadays uncommonly chosen as the surgical approach, but still has its importance in selected cases.

Objectives and methods: To present a clinical report of an open pyelolithotomy plus cystolithotomy performed in our center and review the applicability of open surgery.

Clinical case: A 25 year-old female patient presented in the emergency department with acute left flank pain. Five years before, during pregnancy, she had a left renal colic due to an ureteral calculus, motivating the placement of a double J stent. She was a non-compliant patient, missing multiple subsequent appointments. The X-ray documented a left calcified double J stent, with a staghorn kidney stone and a large intravesical stone. Due to patient's pain complaints, socioeconomic status and probability of non-compliance with multiple surgeries and hospital admissions, we performed an open pyelolithotomy and a cystolithotomy plus a double J stent placement in the same operatory time.

Results: The operative time was 240 minutes with an approximate blood loss of 100 mL. The postoperative abdominal X-ray confirmed that the patient was stone free. The patient was discharged at the 4th postoperative day with no complications. Ureteral stent was removed after 2 months, and the subsequent month was uneventful. The patient missed the following appointment on follow-up.

Discussion/Conclusions: Calcification of ureteral stents is a well know problem, with a rate of incrustation of 76% at 12 weeks. The main risk factors are: low schooling, time of use, post-operative pyelonephritis or sepsis, chronic kidney disease, recurring or residual kidney stones, physiological changes during pregnancy, congenital and metabolic abnormalites. There are several approaches suitable for the treatment of both staghorn kidney stones and intravesical stones. Nowadays, in developed countries, due to the advances in minimally invasive surgery, the need for open surgery approaches only 1%. In selected cases, such as complex stone burden, renal anatomic anomalies, failed minimally invasive previous atempts, socioeconomic status precluding multiple surgeries, contraindications for mini-invasive therapies or in cases of material unavailability, open surgery still represents a valid option.

PO 11

A CASE REPORT OF A TESTICULAR EPIDERMOID CYST – A BENIGN CHAMELEON

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Introduction: Benign intratesticular tumors are rare, accounting for <1% of all testicular tumors. The most common type of benign lesions are the testicular epidermoid cysts (TEC), representing 1-2% of all testicular masses. These are smooth shaped and generally filled with keratinised debris. Patients tipically present in the 2 nd to 4th decades of life with a nontender testicular enlargement, and normal Alpha fetoprotein (AFP), β human chorionic gonadotropin (β-HCG) and lactate dehydrogenase (LDH) levels. Radiologically, TEC can be confused with malignant tumors, leading to a challenging differential diagnosis. Their ultrasonographic features are: intratesticular lesion, well-demarcated, avascular, with laminated appearance, also known as "onion ring". They may be multiple or bilateral. Orchiectomy and conservative testis--sparing surgery are both suitable treatment options but the last one is the most recommended due to the favorable clinical course. Despite their benign character, without risk of metastization, rare cases of complex TEC with simultaneous germ cell testicular tumors (GCTT) were already reported.

Objectives and methods: To present a rare case of a benign intratesticular tumor and review the clinical features and treatment options of TEC.

Clinical case: A healthy 40 years-old man presented in our consultation with a right painless testicular enlargement, with 2 months of evolution. Physical exam revealed a nontender right intratesticular slightly firm mass with 3 cm. Testicular ultrasound revealed a central, circumscribed, heterogeneous, hypoechoic mass in the right testis, with 31 x 21 mm, with no vascular flow detected; epididymis was normal and there was no hydrocele or varicocele. Laboratory evaluation included AFP, β -HCG and LDH, all of which were normal. The thoraco--abdomino-pelvic C T scan was also normal. A right inguinal radical orchiectomy was performed and the histopathologic examination disclosed a 3,7 cm TEC. The procedure and first 6 months of follow-up were uneventful.

Discussion/Conclusions: TEC are rare benign lesions. The current standard treatment is conservative surgery but due to their rarity, radiological similarities to GC TT and to their potencial coexistence with GC TT, they are mostly identified as a histological finding after radical orchiectomy. The key to an accurate identification is the characteristic radiological features in association to negative tumor markers, followed by an extemporaneous excisional biopsy to exclude malignancy.

PO 12

PRIMARY TESTICULAR LYMPHOMA – A RARE TESTICULAR NEOPLASM

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Introduction: Primary testicular lymphoma is a rare entity, accounting approximately 5-9% of all testicular neoplasms, and 1% of all non-Hodgkin lymphomas. The most common histo-type is large B cell lymphoma. This is the most common testicular neoplasm among elderly men, with the average age of diagnosis being 65 years.

Case report: An 87-year-old male patient, with a medical history of hypertension, ischemic coronary disease and dyslipidemia, was admitted to the urology outpatient clinic with enlargement of the left testicle for three months. On physical examination, he had a good general condition, and there was a 4 cm palpable mass on the left testicle, with dull consistency. It was performed a scrotal ultrasound which revealed augmented dimension and vascularization, with associated hydrocele. The right testicle had no alterations. One month later he presented to the emergency department with left flank and hypochondrium pain. The laboratory evaluation showed thrombocytopenia, without other relevant alterations. Computerized Tomography to the abdomen and pelvis revealed a slightly augmented spleen with hypodense areas, suggestive of infarction. The patient underwent a Magnetic Resonance Imaging after being hospitalized for etiologic investigation. It exhibited splenomegaly (16,6x7,7x14,5 cm), associated with peripheral areas of infarction, minimal perisplenic ascites and enlargement of latero-aortic and retro-cava lymph nodes. Extensive laboratory investigation revealed negative tumor markers (alpha-fetoprotein 1,6 U/L and beta-human chorionic globulin 0.6 mU/ml).

Given the high suspicion of testicle tumor, without being able to rule out a lymphoproliferative disease, the patient underwent left radical orchiectomy. The pathological evaluation was compatible with lymphoid neoplasm of diffuse pattern, constituted by arge cells with indistinctive cytoplasm, irregular nuclei, with vesicular chromatin and prominent nucleolus. On immunohistochemistry the cells were positive for CD20, BCL-6, BCL-2, MUM-1 and CD5 and negative for CD3, CD21, CD2, C-myc, D1 Cyclin, CD10. Ki67 was around 80%. The diagnose of non-Hodgkin high grade diffuse large B-cell lymphoma primary of the testicle was established. During the postoperative period, the patient developed a daily fever, despite antibiotic treatment, associated with bilateral pleural effusion and anemia. The patient died on the 17thpost operative day.

Discussion/Conclusion: Primary testicular lymphoma is an aggressive neoplasm, with poor prognosis compared to other non-Hodgkin lymphomas. The first diagnostic and therapeutic procedure performed in testicular lymphoma cases is orchiectomy. As this is a very rare form of non-Hodgkin lymphoma, there is still no robust evidence regarding adjuvant treatment and a high clinical suspicion for this entity is essential for an appropriate and fast treatment.

PO 13

A CASE REPORT OF A BIRT-HOGG-DUBÉ SYNDROME ASSOCIATED KIDNEY TUMOR

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Introduction: Hereditary kidney tumors are uncommon in Urology. The clinical presentation, similarly to other kidney tumors, has shifted in the last decades, being nowadays usually an incidental finding during imaging studies. The management varies since the aggressiveness of each tumor differs depending on disease. However, since there is a predisposition to recurrence and bilateral evolvement, nephron sparing techniques are often preferred.

Goals: To present a rare case of a bilateral kidney tumor associated with Birt-Hogg-Dubé syndrome and review the clinical features and management.

Methods: The information in the clinical file of the patient was used.

Results: A 53-year man with a history of intellectual disability and sensorineural deafness was referred to our consultation with an incidental finding of a 12 cm mass on the right kidney tumor on an ultrasound. On the physical exam there was a palpable kidney mass on the right flank of the abdomen. There were no laboratory changes and, on the CT, there were bilateral kidney tumors, almost countless. On the left kidney, the largest had 2 cm, while on the right side the largest had 12 cm, there was no evidence of adenopathies and metastatic spread. The patient was discussed in multidisciplinary oncological meeting and proposed to a right radical nephrectomy. The patient was submitted to open radical nephrectomy, the procedure complicated on the following day with local hematoma that was evacuated on the OR. The pathological report identified multiple oncocytic tumors and renal oncocytosis, typically associated with Birt-Hogg-Dubé syndrome. The patient had a full recovery and has no complaints.

The patient was discussed and proposed to genetic evaluation and surveillance of the tumors on the left kidney. At one year follow up, the left kidney tumors have remained stable.

Discussion/Conclusions: Birt-Hogg-Dubé syndrome is a rare genetic disease with an autosomal dominant trait, associated with the FLCN gene which produces the folliculin protein on the 17 chromosome. It is frequently associated with the formation of pulmonary cysts and therefore spontaneous pneumothoraxes, cutaneous fibrofolliculomas and chromophobe RCC and oncocytomas. Most renal tumors associated have limited aggressiveness, however, metastatic spread has been described. The proposed approach in surveillance when the tumor size is smaller than 3 cm. Surgery with nephron sparing modalities is preferred when tumor size is larger than 3 cm.

PO 14

RETROPERITONEAL HEMATOMA IN THE PUERPERIUM – A CASE REPORT

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Introduction: Retroperitoneal hematomas in the puerperium are a rare clinical condition, but with a great associated importance, due to the high morbidity and mortality. The diagnosis is challenging and there must be a high level of clinical suspicion. Its approach varies according to clinical stability, with both conservative treatment and surgical treatment available, with abdominal exploration or angioembolization.

Goals: Presentation of a clinical case of postpartum retroperitoneal hematoma, demonstrating its management.

Methods: The information in the clinical file of the patient was used.

Results: A 37 years old, postpartum woman, with eutocic vaginal delivery 8 days ago, with previous 3 other eutocic deliveries, went to the Emergency Department due to severe right lumbar pain, anorexia and asthenia. Upon observation, the patient was tachycardic, hypotensive, apyretic, with a painfull abdomen with peritoneal reaction. In the complementary tests, hemoglobin was 9g/dL, and on the CT scan, there was a large right retroperitoneal hematoma measuring 30/12.5/8 cm in length with active hemorrhage in the portal phase, without identifying a vessel of origin.

Supportive measures were instituted, however the patient progressed to hemorrhagic shock, so she underwent emergent laparotomy. Intraoperatively, active hemorrhage was identified in the retroperitoneum with rupture of the ovarian veins and avulsion of their insertion from the inferior vena cava. Hemorrhage control was carried out with distal ligation of the ovarian veins and suture of the inferior vena cava.

Postoperatively, there was gradual clinical stabilization, however due to evisceration associated with intestinal subocclusion and infection of the remaining hematoma, 10 days later, the patient was reoperated. The patient subsequently had a favorable clinical evolution and was discharged two weeks later.

Discussion/Conclusions: Retroperitoneal hematomas in the puerperium are a rare event that may occur spontaneously and are associated with morbidity and mortality that can exceed 50%. Childbirth is identified as a predisposing factor due to the associated stress as well as hemodynamic changes, namely vascular wall resistance, cardiac output, venous engorgement and blood volume.

The clinical presentation is usually acute or subacute with abdominal or low back pain, tachycardia, hypotension and fever. The diagnosis is confirmed by imaging tests, namely CT. Treatment is based on the patient's clinical stability and the existence of active bleeding. In the presence of hemodynamic stability and absence of active hemorrhage, it can be approached with conservative treatment. In case of hemodynamic instability, surgical treatment with laparotomy is the preferred option. Angioembolization is an option in stable patients with active bleeding, with success in some clinical cases reported in the literature.

PO 15

IATROGENIC URETERAL LESION – THE IMPORTANCE OF TIMELY MANAGEMENT

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Introduction: Iatrogenic ureteral injury is the most common cause of ureteral injury. Most cases occur in gynecological surgery, followed by colorectal surgery. The risk of iatrogenic injury increases in patients with anatomical alterations, due to previous surgery or endometriosis, among other risk factors.

Case report: A 40-year-old female with a history of endometriosis and 2 ectopic pregnancies. She underwent tubal ligation in 2010 and anterior rectal resection with colostomy in 2019, due to a 15cm colic endometriosis lesion. In June 2022, an attempt of laparoscopic stoma reversal was made, requiring conversion to median laparotomy. Due to extensive pelvic adhesions, without cleavage plan between the rectal stump and the vagina, it was impossible to perform a colorectal anastomosis. In the immediate postoperative period, the patient was hemodynamically stable and apyretic. However, on the 4th day, she began to experience tachycardia and subfe-

brile temperature, with an increase in the volume of abdominal drainage, with a creatinine level of 214.9 mg/dL. An abdominal and pelvic computed tomography with intravenous contrast showed extravasation in the late stages in the left ureter and consequent urinoma, suggestive of ureteral injury. Urethrocystoscopy was performed, and retrograde pyelography revealed dilatation of the left ureter above the iliac vessels, with contrast extravasation and no progression, compatible with complete laceration of the left lower ureter. A ureteral catheter was placed for reference. Median re-laparotomy was performed, identifying the proximal end of the left ureter, which was tortuous and entered the obturator fossa. To identify the distal end, methylene blue was injected through the catheter, confirming its location and complete laceration. Transposition of the proximal end of the ureter, spatulation of ureteral ends and mucosa-to-mucosa anastomosis were performed, with ureteral stent. The postoperative period was uneventful, having maintained vesical catheterization for 3 weeks and the stent for 8 weeks.

Conclusion: Although uncommon, ureteral injuries are associated with serious complications, like urinoma, abscess, septic shock and chronic kidney disease. Ideally, the diagnosis is intraoperative, and the management is immediate. However, in about 50-70% of cases the diagnosis is made in the postoperative period. The patient may present with lower back pain, fever, acute kidney injury or increased volume of abdominal drainage. Early recognition and prompt intervention reduce the risk of complications. The initial approach is endoscopic, with a success rate of 14-19%, thus a surgical approach is often necessary. In lower ureter injuries, the technique used is mostly ureteral reimplantation. Given the location of the laceration and the extensive adhesion process and inherent anatomical changes, end-to-end anastomosis was preferred.

PO 16

THE CHALLENGE OF DECISION TOWARDS A CASE OF EXTRARENAL RENAL CELL CARCINOMA

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Introduction: Renal cell carcinoma (RCC) is the most common solid lesion of the kidney. The most frequent histo-type is clear cell RCC, followed by papillary RCC (type I and II) and chromophobe. Primary extrarenal RCC is defined exclusively by the presence of RCC in extrarenal tissue, with normal kidneys.

Results: A 62-year-old man was admitted to the outpatient clinic due to a right adrenal incidentaloma found on an abdominal ultrasound. A CT and a MRI were performed, revealing a 7,7x4,1x4,9 cm bilobed nodule of heterogeneous density, in closed proximity with the inferior vena cava, without any evidence of renal lesions or adenopathies. The patient underwent right adrenalectomy through median laparotomy. The histopathological exam showed a type II papillary RCC, with 7,5 cm and clear margins. 3 months later he did an abdominal and pelvic MRI where a 10x6 mm nodule of the left adrenal (LA) was found. A PET, thoracic CT and cerebral MRI were also executed, without any suspicious lesion, thus he maintained clinical surveillance. After a year, an increment in the size of the LA mass was observed on the abdominal MRI. An endoscopic ultrasound with biopsy was performed, and the histology was compatible with papillary RCC. The patient was then submitted to left adrenalectomy through retroperitoneoscopy. The histopathological exam was compatible with tumor recurrence. The case was discussed in oncological multidisciplinary team, and clinical surveillance

was suggested. The MRI performed 1 year later showed local recurrence of the tumor, invading the splenic artery and the pancreatic tail. The patient was submitted to multiorgan resection, involving the lesion, the spleen, and the distal pancreas. Pathology revealed recurrence of papillary RCC, with clear margins. In the absence of evidence of active disease and a R0 resection, no adjuvant therapy was proposed. He maintained surveillance, undergoing biannual MRI and annual PET until the 4th year of follow up, when hepatic, pulmonary and peritoneal metastases were found. He started palliative treatment with Sunitinib. After 1 month of treatment, he was admitted to the emergency room with aphasia and headaches. A cerebral CT and MRI revealed multiple secondary lesions, the largest located in the left temporal region, causing mass effect. A craniotomy with exeresis of this lesion was performed. The patient died on the postoperative period with intracranial hemorrhage. Since the diagnosis of incidentaloma, no renal lesion was found.

Conclusions: There are very few cases in the literature regarding primary extrarenal RCC and this is the first one with bilateral involvement of the adrenal glands. It is thought that extrarenal RCC might have its genesis in the embryonic mesonephric remnants. This report is intended to alert physicians for the timely recognition of this rare entity, as there are no guidelines regarding follow-up, neoadjuvant or adjuvant therapy.

PO 17

A PECULIAR CAUSE OF SHOCK: ANALYSING TWO CLINICAL CASES

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Introduction: Pheochromocytoma is a rare neoplasia arising from the adrenal medulla that secretes catecholamines. Those afflicted by this condition can present a wide range of symptoms. One of the most common is paroxysmic hypertension possibly combined with headaches, diaphoresis, palpitations, and chest pain. Interestingly, although rare, some patients present with shock. We describe two cases of pheochromocytoma in which the initial presentation was shock.

Case 1: 49 year-old woman, with a history of resistant hypertension, presented to the emergency department with thoracic pain and fever. EKG, echocardiogram (ECC), and myocardial necrosis markers were compatible with Takotsubo syndrome. Thoraco-abdominopelvic CT demonstrated a staghorn calculus, hydronephrosis, and signs compatible with xanthogranulomatous pyelonephritis in the right kidney. Additionally, and incidentally, the CT revealed a 60 mm nodule on the right adrenal gland. Antibiotic therapy with piperacillin/tazobactam was started immediately and the patient was submitted to urgent upper urinary tract drainage with a stent and a nephrostomy tube. This surgical procedure was complicated by a cardiorespiratory arrest that was treated with adrenaline administration. The patient was admitted to the ICU due to multifactorial shock and started alpha and, posteriorly, beta blockage. Biochemical adrenal incidentaloma endocrinologic study was negative (under hemodialysis). Multiorgan failure progressively improved. After two weeks, the patient was submitted to a lapa-

roscopic transperitoneal right adrenalectomy. During the mass dissection, it was necessary to administer labetalol due to hypertensive spikes. During the postoperative period, no complications were reported, and the nephrostomy tube was removed. Patient was discharged on day 15 post-surgery. Histological analysis revealed a pheochromocytoma. Ureterorenoscopy with Thulim laser stone fragmentation was performed 3 months after discharge.

Case 2: 28 year-old woman, with previous history of nephrolithiasis, presented to the emergency department with headaches, and nausea. Vitals were compatible with shock. Thoracoabdominal CT revealed an incidental 72 mm mass on the right adrenal. EKG, echocardiogram (ECC), and myocardial necrosis markers were compatible with Takotsubo syndrome. The patient was started on alpha and, posteriorly, beta blockage. Adrenal incidentaloma endocrinological study demonstrated high urinary catecholamines. Right transperitoneal adrenalectomy was performed. No complications were noted during the intra or postoperative period. Histological analysis revealed a pheochromocytoma.

Conclusion: Pheochromocytoma can present with complex, enigmatic, and rare clinical pictures. Clinicians should be wary of the possibility of this diagnosis when managing adrenal masses.

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