THE SOUTHSIDE OF UROLOGY 2019

SIMPÓSIO DE UROLOGIA

25 e 26 | outubro | 2019

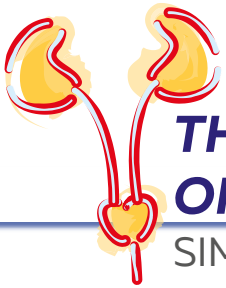
Hotel Tryp Lisboa Caparica Mar

Costa da Caparica

Design: Ad Médic

Scientific Programme

Digital Version



THE SOUTHSIDE OF UROLOGY 2019

SIMPÓSIO DE UROLOGIA

Friday | 25 October

07:45h Opening of registration desk

08:45–09:00h **Welcome Session**
Diretor do Serviço de Urologia do HGO, EPE
Diretor Clínico HGO, EPE
Presidente do Conselho de Administração do HGO, EPE
Presidente do Colégio de Urologia da Ordem dos Médicos
Bastonário da Ordem dos Médicos
Presidente da Associação Portuguesa de Urologia
Presidente da Associação Portuguesa de Neurourologia e Uroginecologia

09:00–11:00h **Renal Cancer – Part I**
Chairs: Avelino Fraga, José Palma dos Reis and Amaral Canelas

09:00–09:30h **Diagnosis of small renal masses**

Role of imaging (15 min.)
António Matos

Renal biopsy: State of-the-art (15 min.)
Lorenzo Marconi

09:30–10:00h **Treatment-Laparoscopy**

T2 renal tumors-radical vs. partial nephrectomy (15 min.)
Nuno Figueira

Transperitoneal vs. retroperitoneal approach (15 min.)
Miguel Ramos

10:00–10:30h **Treatment-robotics**

Partial and radical nephrectomy (15 min.)
Rui Prisco

Intraperitoneal vs. extraperitoneal approach (15 min.)
Pedro Bargão

10:30–11.00h **Panel discussion of clinical cases**
Moderators: João Bastos and Jorge Fonseca
Panel: Pedro Baltazar, Nuno Ramos and Rui Formoso

11:00–11:20h Coffee break and posters evaluation

11:20-13:00h **Renal Cancer – Part II**
Chairs: Aníbal Coutinho, Cardoso de Oliveira and Rui Dinis

11:20-12:20h **Special clinical cases**

Small renal mass – Old patient (15 min.)
Arnaldo Figueiredo

Small renal mass – Obese and young patient (15 min.)
Gustavo Gomes

Vena cava involvement: Open vs. laparoscopic treatment (15 min.)
Tito Leitão

Advanced kidney cancer – Can we avoid nephrectomy? (15 min.)
Marco Dores

12:20-12:30h **Discussion**

12:30-13:00h **Renal Cancer – Part III –** Industry Symposium
Bristol-Myers Squibb
First line and second line treatment of RCC
André Mansinho

13:00-14:30h Lunch and posters evaluation

14:30-17:00h **Urothelial and bladder cancer – Part I**
Chairs: Paulo Vale, José Miguel Leal de Carvalho and Nuno Figueira

14:30-15:00h **Genetics and markers in urothelial cancer**

The new age of - *omics* in urothelial cancer (15 min.)
Belmiro Parada

Prognostic markers in bladder cancer (15 min.)
Luís Mascarenhas

15:00-15:30h **Diagnosis and staging of urothelial cancer**

Advancements in optical techniques in the diagnosis and management of urothelial cancer (15 min.)
Paulo Jorge Dinis

Multi-parametric MRI for diagnosis of invasive urothelial cancer (15 min.)
Miguel Ramalho

15:30-16:30h **Treatment of urothelial cancer – Urologist approach**

Conservative management of upper tract cancer (15 min.)
Miguel Ramos

Intravesical therapy – BCG and beyond (15 min.)
Nuno Fidalgo

Radical cystectomy – State of-the-art (15 min.)
Estêvão Lima

Functional outcomes after radical cystectomy (15 min.)
Paulo Temido

16:30-17:00h **Panel discussion of clinical cases**
Moderators: Nuno Pires and João Varregoso
Panel: Sandro Gaspar, Alexandre Macedo and Álvaro Nunes

17:00-17:20h Coffee break and posters evaluation

17:20-18:00h **Urothelial and bladder cancer – Part II**
Chairs: Hélder Mansinho, Eduardo Silva and Fernando Ferrito

17:20-17:50h **Special clinical cases**

Low volume MIB (15 min.)
Tiago Lopes

Young female patient with MIB (15 min.)
Vanessa Metrogos

17:50-18:00h **Discussion**

18:00-18:30h **Urothelial and bladder cancer – Part III –** Industry Symposium
Roche
Moderators: José Miguel Leal de Carvalho e Hélder Mansinho

Treatment of metastatic Urothelial Cancer – The impact of Immunotherapy (30 min.)
Belmiro Parada

Saturday | 26 October

07:30h Opening of registration desk

08:00-08:30h **Best 3 poster and best 3 video - Presentations**
Chairs: João Marcelino, Rui Sousa and Pedro Nunes

08:30-10:45h **Prostate cancer - Part I**
Chairs: Nuno Pires, Luís Campos Pinheiro and Maria José Brito

08:30-09:15h **Histopathology and diagnosis**

What´s new in prostate pathology? (15 min.)
Diogo Gonçalves

Should mp-MRI be used routinely? (15 min.)
Pedro Galego

Prostate biopsy – State of-the-art (15 min.)
João Pina

09:15-10:15h **Active surveillance and surgery**

Active surveillance vs. focal therapy (15 min.)
Gil Falcão

Open radical prostatectomy – Old fashion? (15 min.)
Pedro Monteiro

Laparoscopic radical prostatectomy – A king without trone? (15 min.)
Rodrigo Ramos

Robot-assisted radical prostatectomy – The future? (15 min.)
Kris Maes

10:15-10:45h **Panel discussion of clinical cases**
Moderators: João Paulo Rosa and Pedro Soares
Panel: Raquel João and Joana Alfarelos

10:45-11:15h Coffee break

11:15-12:00h **Prostate cancer – Part II**
Chairs: Estêvão Lima, Inmaculada Maldonado and Francisco Campos

11:15-12:00h **Radiation, recurrence and advanced disease**

Radiotherapy and brachytherapy in localised disease (15 min.)
Celso Marialva

Recurrence – Risk factors and staging (15 min.)
Andrea Furtado

Locally advanced disease – Treatment (15 min.)
José Dias

12:00-12:30h **Prostate cancer - Part III**
Chairs: Ana Isabel Santos and António Madeira

12:00-12:30h **Bone metastasis and novel agents**

Treatment of bone metastasis (15 min.)
Carlos Rabaça

Imunotherapy and new agents (15 min.)
Pedro Nunes

12:30-13:00h **Treatment of metastatic PCa and CRPC –** Industry Symposium
astellas
Speakers: José Dias and Tiago Oliveira

How to deal with oligometastatic patients (15 min.)

Non-metastatic and metastatic CRPC – Current treatment paradigms (15 min.)

13:00-13:30h **Panel discussion of clinical cases**
Moderators: Fernando Calais da Silva and Fortunato Barros
Panel: Vanessa Metrogos, Carlos Monteiro and Francisco Campos

13:30-15:00h Lunch and Best poster and video Prizes

15:00-16:30h **LUTS / BPH Course**
Chairs: Miguel Lourenço and Frederico Ferronha

When tests are "normal" and complaints persist;
The importance of clinical history and dynamic examinations in LUTS (25 min.)
Hugo Pinheiro

Erectile dysfunction and LUTS;
Simultaneous approach? (25 min.)
Catarina Gameiro

Minimal invasion = minimal complication with the same results?;
From embolization to open prostatectomy (25 min.)
José Carlos Santos

Discussion

16:30-18:00h

Urinary lithiasis Course

Chairs: Peter Kronenberg and Garção Nunes

Acute flank pain;
Diagnostic workup, medical and surgical treatment of patients with renal colic (25 min.)
Paulo Príncipe

Urinary lithiasis in the young patient;
Diagnostic and treatment strategies (25 min.)
Renato Mota

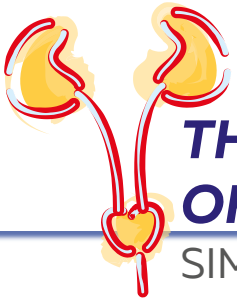
Long-term management of recurrent kidney stones (25 min.)
Frederico Furriel

Discussion

18:00h

Closing session of The Southside of Urology 2019

Chair: José Miguel Leal de Carvalho
Panel: António Madeira, João Bastos, Nuno Bello, João Paulo Rosa, Francisco Campos, Nuno Fidalgo, Nuno Figueira, Vanessa Metrogos, Nuno Ramos, Alexandre Macedo



THE SOUTHSIDE OF UROLOGY 2019
SIMPÓSIO DE UROLOGIA

Abstracts | Posters & Videos

Posters

P 01

PRIMARY RENAL ANGIOSARCOMA: A CASE REPORT

Diogo Pereira; Raquel Machado-Neves; Raquel Catarino; Gabriel Costa; Tiago Correia; André Cardoso; Frederico Carmo Reis; Manuel Cerqueira; Manuel Jacome; Rui Prisco
ULS Matosinhos - Hospital Pedro Hispano

Introduction: Angiosarcoma is a malignant neoplasm of endothelial cells. It accounts for less than 2% of soft tissue sarcomas. Primary angiosarcoma of the kidney is a rare tumor with only a few case reports in the literature. There is a male predominance and it is more frequent in the 6th to 7th decade. Its etiology is unknown. Patients usually present with flank pain, hematuria, abdominal mass and weight loss. A considerable number of patients present with metastatic disease at diagnosis or developed it shortly afterwards. The mainstay of treatment is surgery followed by radiation therapy with or without chemotherapy.

Goals: To describe a case report of a patient diagnosed with a renal angiosarcoma.

Methods: Retrospective analysis of a case report and its description.

Results: This is a case of a smoking 61-year-old man followed in the gastroenterology consultation due to melena and weight loss. CT enterography showed a large complex cystic lesion in the left kidney and the patient was oriented to the urology appointment. MRI demonstrated an exophytic nodular lesion with 13cm in width with thick and irregular walls. A radical nephrectomy was performed, and the pathological anatomy analysis showed a renal angiosarcoma. It is recommended that cases similar to this should be managed by a specialist multidisciplinary team with experience and expertise in sarcoma, so the patient was referred for a Reference Center in our country. He developed metastatic disease a few months after.

Discussion/Conclusions: Renal angiosarcomas are highly aggressive tumors with a poor prognosis. They must be distinguished from morphologically similar lesions of the kidney and be managed by a multidisciplinary team.

P 02

INVASÃO PERINEURAL NA BIÓPSIA PROSTÁTICA. UM PREDITOR DE RECORRÊNCIA BIOQUÍMICA APÓS PROSTATECTOMIA RADICAL?

Nuno Ramos; Vanessa Metrogos; Alexandre Macedo; João Paulo Rosa; Miguel Carvalho
Hospital Garcia de Orta, EPE

Introdução: *Cerca de 18% dos doentes submetidos a Prostatectomia Radical (PR) para tratamento de carcinoma da próstata (CaP) localizado, podem apresentar recorrência bioquímica (RBQ). Portanto, é crucial identificar os doentes com maior risco de RBQ. A invasão pe-*

rineural (IPN) é considerada um dos principais mecanismos de disseminação extraprostática do CaP, tendo sido apontado como um potencial marcador de prognóstico. No entanto, apesar do IPN poder estar associado a fatores anatomopatológicos adversos, ainda está em debate o seu papel como preditor de recorrência bioquímica.

Objetivo: *Este trabalho tem como objetivo avaliar se a deteção de invasão perineural na biópsia prostática tem impacto na recorrência bioquímica, em doentes submetidos a Prostatectomia Radical.*

Métodos: *Foi efetuada uma análise retrospetiva dos doentes diagnosticados com CaP e submetidos a PR, no período de janeiro de 2009 a dezembro de 2016, no nosso serviço. Foram avaliadas as características clínicas dos doentes, assim como, os fatores anatomopatológicos da biópsia prostática (nomeadamente a IPN) e da peça cirúrgica, tendo sido correlacionados com a RBQ. A sobrevivência livre de RBQ foi calculada através da análise de Kaplan-Meier. O impacto da IPN na RBQ foi avaliado pelo modelo de regressão de Cox.*

Resultados: *A amostra analisada é constituída por 107 pacientes, com idade média de 63 anos e PSA médio prévio à biópsia de 7,8 ng/ml. Na biópsia prostática, 66,4% dos casos apresentavam Score de Gleason 6 (3+3), 30.9% Gleason 7 e 2.7% Gleason ≥ a 8, tendo sido detetado IPN em 53,3% dos doentes estudados. Em relação às categorias de risco da D'Amico,60.7% dos tumores eram de risco baixo, 27.1 % risco intermédio e 12.2% risco alto. Analisando as caraterísticas anatomopatológicas da peça operatória, observou-se invasão tumoral das vesículas seminais em 6,5%, doença ganglionar em 9.3% e margens cirúrgicas positivas em 27,1% dos casos, sendo estas multifocais em 12,2%. Quando comparado o Score Gleason da biópsia prostática com o da peça operatória observou-se upgrade em 24,2% dos casos. Durante o follow-up dos doentes, registou-se RBQ em 24,3% dos casos. As características clínicas e anatomopatológicas foram estratificadas em função da presença de IPN na biópsia prostática, existindo significância estatística na amostra, em relação Score de Gleason da peça (p=0.001), estadiamento patológico (p=0.001), categorias de risco da D'Amico (p=0.002) e upstaging do Score de Gleason (p=0.045) . Foi também identificado relação estatística entre IPN e a RBQ (hazard ratio [HR] = 2.16; 95% CI: 1.02–4.58; p =0.044). As curvas de Kaplan-Meier, com avaliação da sobrevivência livre de RBQ, revelaram diferença em função da presença de IPN na biopsia prostática (p=0.04).*

Conclusões: *Este estudo revela que a presença de IPN na biopsia prostática, está relacionada com fatores anatomopatológicos adversos, sendo um potencial preditor de RBQ em doentes submetidos a PR. Estes resultados deverão ser confirmados com um estudo prospetivo.*

P 03

RHABDOMYOSARCOMA IN UNREPAIRED EXSTROPHIC BLADDER FROM A GIRL WITH OEIS COMPLEX

Sofia Ferreira de Lima[1]; Fátima Alves[1]; Vanda Pratas Vital[1]; Rafaela Murinello[1]; Ximo Duarte[2]; Francisco Sant'Ana[3]; Rui Alves[1]

[1]Serviço de Cirurgia Pediátrica, Hospital Dona Estefânia- CHLC; [2]Serviço de Pediatria, Instituto Português de Oncologia de Lisboa Francisco Gentil; [3]Serviço de Ortopedia, Hospital Dona Estefânia - CHLC

Exstrophy of the bladder is a rare congenital malformation and is associated with an increased incidence of bladder carcinoma. The case described herein of a rhabdomyosarcoma of embryonal variety in unrepaired exstrophic bladder is a very rare finding. The authors found only one other case in literature that reported the association of rhabdomyosarcoma and exstrophic bladder, dated back to 1972.

We report a case of a 16-month old girl, born at 35 weeks after an uneventful pregnancy without teratogen exposure. She had multiple congenital

anomalies. Physical examination revealed an omphalocele, exstrophic bladder with pubic separation, imperforate anus, and giant hemangioma of the thigh and leg. Underdeveloped genitalia was present but no vagina was visible. She was submitted to surgery in first day of life were intestinal malrotation with minor omphalocele was observed. There was a didelphys uterus which communicated with bladder and with a blind rectum trough a fistula. The omphalocele and malrotation were repaired. Partial bladder closure with vesicostomy and divided colostomy were performed. Radiographic studies revealed right renal agenesia. Genetic analysis revealed 46 XX karyotype and a dup 2p11.2. A sagittal posterior anorectoplasty and colostomy closure were done at 8 and 11 months of age, respectively.

When the child was 14 months - old she presented with a polypoid mass with more than 5 cm dimension, partially occupying her bladder and prolapsing through vesicostomy. Biopsy revealed embryonal rhabdomyosarcoma, positive for myogenin. The metastatic evaluation with CT was negative. Patient started on chemotherapy according to subgroup B/C of Protocol EpSSG RMS2005 (D-Actinomycin, Vincristine and cyclophosphamide every 3 weeks, 9 courses), with tumour response. After chemotherapy the patient underwent radical cystectomy, total hysterectomy, symphysis pubic closure, and terminal ureterostomy with no complications. The convalescence was uneventful.

OEIS is the acronym for a malformations complex association consisting of omphalocele, exstrophy of bladder or cloaca, anal imperforation and spinal defects. This multisystem malformation represents the most severe phenotype of the bladder exstrophy-epispadias complex spectrum. Its incidence is rare, thought to occur in 1 in 200,000 to 1 in 250,000 live births. The etiology of OEIS is unknown. Most cases are sporadic but there are reports of occurrence in siblings and twins suggesting a genetic contribution to the pathogenesis of OEIS complex. It has been shown to be associated to Opitz G / BBB, Goltz syndrome, among others, trissomies 13, 18 and some gene mutations.

There are numerous congenital syndromes, associated with an increased risk of rhabdomyosarcoma development. There is no known association between OEIS complex and embryonal rhabdomyosarcoma.

The increased incidence of bladder cancer in exstrophic bladder is several times greater than in age-matched controls in general population. The etiology of this increased incidence remains unclear, one theory holds that the chronic irritation and infection lead to metaplasia of urothelium. Approximately 90% of cancers occurring in exstrophic bladders are adenocarcinomas and 5% are squamous cell carcinomas.

This case is important for its rarity and therapeutic challenge. It elucidates the importance of a multidisciplinary approach. Subspecialties must work together to tailor therapy to individual patient and tumour characteristics.

P 04

GIANT ANGIOMYOLIPOMA: AD MINIMUM PARTIAL NEPHRECTOMY

André Marques Pinto; Lafuente de Carvalho; Manuel Castanheira de Oliveira; Miguel Silva Ramos; Avelino Fraga
Centro Hospitalar Universitário do Porto

Introduction: Angiomyolipomas (AML) are the most common benign kidney tumours, a mesenchymal tumour consisting of perivascular epithelioid cells. An AML is composed of varying proportions of vascular cells, immature smooth muscle cells, and fat cells. AML are typically found in the kidney, but have also been found elsewhere.

AML may grow rapidly, up to a point that impairs kidney function or causes rupture, leading to haemorrhagic shock.

AML are strongly associated with tuberous sclerosis (TS), and lymphangioleiomyomatosis

(LAM). However, 85% of cases are sporadic. Whether inherited or sporadic, AML are caused by mutations in either the TSC1 or TSC2 genes, which control cell proliferation.

Ultrasound is particularly sensitive to the fat in AML. Yet, CT is very detailed and allows accurate measurement. Some other kidney tumours contain fat, so the presence of fat is not diagnostic.

Incidental discovery of AML should trigger consideration of TS and LAM. Screening for TS includes a detailed physical exam, including dermatologic and ophthalmologic evaluations, and a brain CT. Screening for LAM includes a high-resolution chest CT.

Everolimus is approved for the treatment of AML larger than 3 cm.

Some centres perform preventative selective AML embolization, in tumours larger than 4 cm, due to haemorrhagic risk. In selected patients, a partial nephrectomy may be required. Since kidney function may already be impaired, preserving as much kidney as possible is crucial.

Goals: We hereby describe a clinical case regarding the management of a giant renal angiomyolipoma.

Methods: Review of medical reports and relevant literature.

Results: A 28 year-old woman was referred to our institution due the incidental finding of several renal nodules (ranging from 0.5 to 6cm) on ultrasound in 2012. A CT scan confirmed the presence of more than 30 hypodense nodules, most likely AML - the largest was in the upper pole of the left, measuring 7.5cm. There were no dermatological lesions suggestive of TS. Brain CT excluded the presence of brain lesions, and lung CT excluded LAM. She had no relevant medical history in her family. She underwent embolization of the left upper polar renal artery one month later. The follow-up CT scan showed a significant regression of the vascular component, but the lipomatous component persisted with 2.5cm. The genetic tests for TSC1 and TSC2 turned out negative. She gave birth in 2016 and a follow-up ultrasound later showed a progression of AML. A CT scan confirmed a 16.5 upper polar AML on the left with scant vascular component. She was proposed a partial nephrectomy by flank approach. The surgery took place in 2019 as planned, lasting 75 minutes. The nodule was dissected from the anterior renal capsule and a small pedicle from which it was attached was ligated. There was no ischemia. The patient was discharged home in the third post-operative day and there is no record of complications to date. Histopathology confirmed an AML, and genetic testing is undergoing. The patient is to start everolimus.

Discussion: Despite benign, AML have been known to grow rapidly (as much as 4 cm in one year), and pose a significant risk of rupture, which is a medical emergency, as it is potentially life-threatening. Giant AML refractory to embolization may be treated surgically in a safe kidney-sparing way. We describe a partial nephrectomy with minimal renal mass removal, as AML may have a minute pedicle despite its size and just lay over the kidney.

P 05

METASTATIC RENAL CELL CARCINOMA – SAILING FROM DIAGNOSIS TO THIRD LINE SYSTEMIC THERAPY

André Barcelos; Pedro Bargão Santos; Lobato Faria; Fernando Ferrito
Hospital Professor Doutor Fernando Fonseca

Renal cell carcinoma (RCC) is the most common type of kidney cancer. About 30% of people with RCC have already developed metastases at presentation, and about 20% of people develop metastases during the course of the disease, despite treatment. The 5-year relative survival of Metastatic Renal Cell Carcinoma (MRCC) is around 10%. RCC has long been identified as an immunogenic malignancy. Various immunotherapeutic approaches have been developed

for the treatment of MRCC, including tyrosine kinase inhibitors and checkpoint inhibitors. During the last years, the treatment algorithms have changed for both the first and subsequent therapeutic lines.

We report a case of a 66 years old man, diagnosed with MRCC that underwent radical nephrectomy and is now under the third line of immunotherapy.

The patient was observed in the emergency department due to macroscopic haematuria. During the study of the haematuria a CT Urography was performed and it identified an infiltrating lesion in the right kidney with 8.5cm of diameter, along with a tumoral thrombus occupying the entire right renal vein, extending to the inferior vena cava. The CT Urography also showed a 3cm adenopathy adjacent to the celiac trunk and in the pulmonary parenchima lesions compatible with metastasis.

A radical nephrectomy with thrombectomy was performed. The pathological examination revealed a Clear Cell Carcinoma, Fuhrman Grade 2 – pT3aR0. His Karnofsky performance status (PF) was 100 and according to the IMDC (International Metastatic RCC Database Consortium) Risk Model for MRCC it was a "favorable risk". 3 months after surgery he started the first line of immunotherapy with Pazopanib. He maintained good PF but 6 months after starting Pazopanib the CT showed progression of the ganglonar disease with a stable pulmonary disease (RECIST). So he started second line therapy with Axitinib. The CT 3 months after starting Axitinib revealed a partial response of pulmonary and ganglionar disease but also showed development oh hepatic steatosis (with normal liver function analysis) – the Axitinib dose was reduced. At 9 months after starting Axitinib he developed hepatic toxicity grade II and the CT showed pulmonary and ganglionar progression. Axitinib was suspended and he started Nivolumab.

For the last 6 months he has been under therapy with Nivolumab, with good tolerability, good PF and with no evidence of disease progression. It is now 24 months since diagnosis, and he has done 21 months of immunotherapy (6 months Pazopanib, 9 months Axitinib and 6 months Nivolumab), so far.

To conclude, sequential therapy is recommended for MRCC. However, the optimal sequence of drug administration in sequential therapy is controversial. Recently, the effect of a combination therapy of checkpoint inhibitors and a cytotoxic agent was tested with good results. However, the optimal drug for combination with checkpoint inhibitors is still uncertain. Clarifying the mechanism underlying this phenomenon is the first step to choosing the best drug and sequence of drug administration in sequential therapy.

P 06

A SERIES OF PATIENTS WITH RENAL ANGIOMYOLIPOMAS: DIAGNOSIS AND MANAGEMENT

Vanessa Metrogos; Nuno Ramos; Alexandre Macedo; João Bastos; Miguel Carvalho
Hospital Garcia de Orta

Introduction: Angiomyolipomas (AMLs) are the most common benign renal tumours. Most are found incidentally on imaging. However, symptomatic presentation does exist. Renal AMLs are typically composed of smooth muscle, blood vessels, and adipose tissue. Because of the abundant fat tissue, they give a characteristic appearance on imaging and are therefore easily diagnosed. However, sometimes they do not have macroscopic fat, turning it difficult to differentiate from renal cell carcinoma (RCC). Management of AML is based on clinical presentation and should be individualized for every patient. Treatment modalities range from active surveillance to more invasive approaches.

Objective: To evaluate the aspects related to diagnosis and therapeutic approach of renal AML in our Institution.

Material and methods: We reviewed consecutive abdominal magnetic resonances (MRI) performed from 2014 to 2018 at our institution and selected cases where the report mentioned the presence of renal AML. In addition, the pathological reports of nephrectomy performed during this period were also reviewed, selecting the cases of AML. The clinical data of the selected patients was subsequently consulted.

Results: AML was diagnosed in 32 patients, 3 with tuberous sclerosis. The average and median age at diagnosis was 56.38 (0.25-79) and 14.42 (0.25-37) years. Outside the context of tuberous sclerosis, all patients were diagnosed incidentally (n = 29), showing no morbidity or mortality related to the presence of AML. Lesions occurred unilaterally, most often on the left (n = 16) and in only 3 cases were multiple (> 2 lesions). Only 5 patients were evaluated by urology, of which 1 was discharged to the General Practitioner and the other 4, due to suspected renal atypia, underwent radical nephrectomy (n = 3) or partial nephrectomy (n = 1), with subsequent histological diagnosis of AML. All cases of tuberous sclerosis (n = 3) occurred in male patients. All had bilateral multiple AML, whose mean size of the largest lesions was 55.67mm (35-88mm). All patients were under surveillance for renal AML, except 1 when a 5cm angiomyolipoma ruptured, underwent over-selective arterial embolization and started therapy with mTOR inhibitor (sirolimus). No mortality was found in cases of tuberous sclerosis. The following concomitant morbidity was noted in patients with tuberous sclerosis: epilepsy (n = 2), cognitive impairment (n = 2), face angiofibromas (n = 3), periungeal Konen tumor (n = 3), hypertrophic cardiomyopathy (n = 1).

Discussion/Conclusion: AML are the most common benign renal tumors. They are associated with tuberous sclerosis, but may occur sporadically. The possibility of bleeding is the main concern in their approach. Due to their fat content, they are readily identified on CT or MRI. But low-fat AMLs are a diagnostic challenge. Active surveillance is generally appropriate for asymptomatic small AML. Masses> 4cm or symptomatic are usually treated (radical or partial nephrectomy, selective arterial embolization or ablative techniques such as cryoablation and radiofrequency ablation). Medical treatment with mTOR inhibitors is also an option in patients with tuberous sclerosis to preserve the renal parenchyma. Although with its inherent limitations, this work allowed us to get a global idea of the incidence, diagnosis and therapeutic approach of AML in our institution.

P 07

CLINICAL CHARACTERISTICS OF PATIENTS SUBMITTED TO PROSTATE BIOPSY: IS DIGITAL RECTAL EXAMINATION STILL RELEVANT?

M. Medeiros; F. Fernandes; J. Guerra; R. Tomás; R. Bernardino; G. Falcão; T. Guimarães; V. Andrade; F. Ferronha; L. Campos Pinheiro
Centro Hospitalar e Universitário de Lisboa Central

Introduction: The prostate cancer screening is one of the most controversial topics of today. The individualised assessment can be offered to better informed men regarding the benefits and disadvantages of screening. The suspicion of prostate cancer is based on the digital rectal examination and on the levels of PSA. Taking in consideration that most prostate tumours are located on the peripheral area, the rectal examination can aid the diagnosis when these have significant sizes (>0.2mL). Around 18% of the prostate cancers are detected through suspicious digital rectal examination, regardless of PSA. In addition, it is also known that an abnormal digital rectal exam is associated with a bigger risk of a high Gleason.

Objectives: In this study we are going to assess the clinical characteristics of patients submitted to prostate biopsy with a special focus on the role of digital rectal examination.

Material and methods: We have assessed the clinical characteristics of 300 patients submitted to ecography-guided prostate biopsy.
The following variables were analysed - age, PSA, digital rectal examination and histology, identifying the reason for prostate biopsy.
Results: The average age of patients submitted to prostate biopsy were of 68 years of age, with an average PSA of 19[1-390]. From the biopsies, 134 were positives (44% of patients). Regarding the reasons behind the biopsies, only 71 patients (24%) manifested a suspicious rectal exam. Of these, 41 (58%) exhibited a positive biopsy. Considering PSA values inferior to 4 mg/mL, 13 patients carried out a suspicious rectal exam biopsy, of which only 3 (23%) had a positive histology result.
Conclusion: The retrospective assessment of patients submitted to prostate biopsy have shown that in most cases this is caused by the existence of a suspicious PSA and in patients with a low PSA, the digital rectal examination indicates a predictive positive value for the detection of a reduced prostate tumour - 23%.

Videos

V 01

ROBOT ASSISTED EXCISION OF SEMINAL VESICLE NEOPLASM

Diogo Pereira; Gabriel Costa; Raquel Catarino; Tiago Correia; André Cardoso; Frederico Carmo-Reis; Manuel Cerqueira; José Rocha Almeida; Fernando Ferrito; Rui Prisco
ULS Matosinhos - Hospital Pedro Hispano, Hospital CUF Porto, Hospital CUF Infante Santo

This is a case of a 72-year old man who presented to the urology appointment with a several months history of lower urinary tract symptoms. PSA was within normal ranges and imaging documented a retrovesical nodular lesion adjacent to the right seminal vesicle with 5cm in width. There are several surgical approaches described to excise seminal vesicle lesions. We successfully performed a robotic-assisted laparoscopic excision which lasted for 90 minutes. Anatomopathological report revealed a schwannoma. The patient was discharged two days after the surgery. He had a complete resolution of his complaints. Seminal vesicle neoplasms are extremely rare. Schwannoma is a benign tumor of the peripherical nerves sheath composed by Schwann cells. Most of these tumors are silent and become symptomatic with compression of adjacent organs and nerves. They are usually found in the head, neck, mediastinum and retroperitoneum. Malignant progression is rare and mostly cases of schwannoma are due to sporadic genetic mutations.

V 02

LAPAROENDOSCOPIC SINGLE-SITE PLUS ONE PORT (LESS POP) NEPHROURETERECTOMY

Artur Palmas; Nuno Domingues; Tiago Oliveira
Hospital das Forças Armadas, Lisboa

Introduction: Nephroureterectomy (NU) with bladder cuff excision is the gold standard treatment for patients with upper urinary tract urothelial cancer. In this video we report our laparoendoscopic single-site plus one port (LESS POP) technique for NU and bladder cuff excision.
Material and methods: Though a Gibson incision on the iliac fosse, a single-port device (Gelpoint, Applied Medical, California, USA), were placed. This platform provides a secure and multichannel access, that allows to perform the surgery and easy extraction of large kidneys. After achieving a pneumoperitoneum, an additional 5mm port, is placed, 2 cm lateral the umbilicus. The standard laparoscopic NU is realized, and the cuff excision with perimeatus cystectomy and limphadenectomy, accomplished though the Gibson incision, on a open fashion. At the end of the procedure, the surgical part is removed by the Gibson incision, and the drain is placed, by the additional 5mm port.

Conclusion: LESS POP NU is feasible, and represents an attractive alternative to conventional laparoscopy and single-port surgery. It combines the common principles of traditional laparoscopy (straight instruments and triangulation) with single-port surgery (cosmetic and minimally invasiveness) resulting in adequate time and short learning curve.

V 03

SALVAGE LAPAROSCOPIC PARTIAL NEPHRECTOMY AFTER CRIOABLATION FAILURE

Nuno Domingues; Tiago Oliveira; Artur Palmas
Hospital das Forças Armadas

Introduction: Crioablation has been established as a viable treatment option for clinically localized kidney tumors, particularly for small renal masses. It is an attractive modality for carefully selected patients with tumors smaller than 4 cm. The potential advantages include its minimally invasive nature, reduced perioperative complications, and shorter hospitalization and convalescence periods. The potential limitations include concerns about the increased incidence of local recurrence, controversies regarding the interpretation of follow up imaging studies and the lack of extended follow-up.
However, for local recurrence after thermal ablation, salvage partial nephrectomy, can be challenging due to associated perinephric fibrosis.
Clinical case: In this video, we show a 65 years old patient, that 4 years ago, in a routine ultrasound, detect a small renal mass, with 24mm diameter, middle third of the right kidney. Previous renal biopsy was made that reveals renal cell carcinoma, clear cell, Fuhrman grade II. It was submitted to laparoscopic crioablation outside this institution. 4 years later in the follow up, the CT showed contrast enhancement recurrence of the renal mass, defined as a failure of the crioablation. Local recurrence after crioablation failure is frequently managed by repeat crioablation, but in this case, due to the age of the patient, a surgical salvage option seems to be the most appropriated option.
The patient was submitted to salvage laparoscopic partial nephrectomy. The pathology revealed renal cell carcinoma, clear cell, Fuhrman grade I. In the follow up, 3 months after surgery, the CT scan shows the complete eradication of the contrast enhancement renal mass.
Conclusion: Salvage partial nephrectomy after crioablation failure is feasible, with adequate preservation of renal function, and laparoscopic approach is often possible, but can be challenging due to associated perinephric fibrosis. The difficulty of surgical salvage therapy should be recognized as a potential limitation of the thermal ablation treatment strategy.

V 04

ADVANCED RECONSTRUCTION OF VESICOURETHRAL SUPPORT (ARVUS TECHNIQUE) DURING LAPAROSCOPIC RADICAL PROSTATECTOMY

Nuno Domingues; Tiago Oliveira; Artur Palmas
Hospital das Forças Armadas

Introduction: The advent of laparoscopic and robotics, particularly 3D vision, promoted the development of new surgical techniques for radical prostatectomy. Better knowledge of pelvic anatomy and its functional relationships after prostate removal is of paramount importance to reduce post-prostatectomy incontinence rates and to improve early recovery of continence.
Method: In this video, we present a surgical technique for vesicourethral anastomosis reconstruction during laparoscopic radical prostatectomy using the levator ani muscle for support. In the advanced reconstruction of vesicourethral support (ARVUS) techinque, levator ani muscle fibres, Denonvilliers fascia, retrotrigonal layer and median dorsal raphe are used to form the dorsal support for the urethrovesical anastomosis. From june 2017 to december 2018, a

total of 27 patients were randomly assigned to undergo a laparoscopic radical prostatectomy with either the standard posterior reconstruction using the Rocco stitch (15 patients) or the ARVUS technique (12 patients). We compared preoperative and postoperative functional and oncological results for the two groups. The primary endpoint was continence, evaluated at different time points (24h, 4 and 8 weeks and 6 months). The secondary endpoints were perioperative and postoperative complications and erectile function.

Results: Using a continence definition of 0 pads a day, the continence rates for the ARVUS versus the control group were 20,3% versus 8,3% at 24h (p=0,078), 65,1% versus 25,3% at 4weeks (p<0,01), 70,1% versus 30,2% at 8weeks (p<0,001) and 78,1% versus 45,5% at 6months (p=0,013). International Index of Erectile Function questionnaire results at 6 months showed similar potency rates for the control group 38.5% and the 37,5% in the ARVUS group (38,5% versus 37,5%).

Discussion and conclusion: The ARVUS technique seems to improve urinary continence rates when compared to standard posterior reconstruction, with no negative impact on erectile function, complication rate or oncologic outcome. This could improve the quality of life of patients undergoing radical prostatectomy. More studies are needed to confirm our results.

V 05

LAPAROSCOPIC URETEROLITHOTOMY FOR LOWER URETERIC STONE

Nuno Domingues; Tiago Oliveira; Artur Palmas
Hospital das Forças Armadas

Introduction: Laparoscopic ureterolithotomy is an alternative to open surgery for the removal of large stones not amenable to endoscopic treatment. In most of the published literature, laparoscopic approach of lower ureteric stones is described to be less successful than in the middle and upper ureter. This video describes important technical points to successfully retrieve a large lower ureteric stone through transperitoneal laparoscopy approach.

Clinical case: We present a video of a right laparoscopic ureterolithotomy for a 25 mm lower ureter stone not amenable to endoscopic treatment, in a male 65 years-old patient, with a past history of hypertension and bilateral kidney stone with previous endoscopic surgery.

The patient was placed in dorsal decubitus position with 30 degrees of trendelenburg. We placed the camera at the umbilicus using the Hasson open technique. Subsequently a 10mm port and three 5 mm ports were placed under direct vision, in order to have the best port placement for 2 surgeons.

Due to the absence of haptic feedback, exact site of incision over the stone sometimes becomes challenging. Pinching the ureter gently allows accurate identification of stone location. Once the stone was localized by 'ureteral pinching', the ureter was incised over the stone. With the dissector, the stone was "fished" out and placed in the laparoscopic specimen bag. Once the stone was taken out, a double J stent was placed by laparoscopic approach. After the stent was in place, a 3/0 V-Lock was used to close the ureterotomy. A tubular drain was placed before closing the ports. Operating time was 150 min. Urethral catheter was taken out first and then the drain. The patient was discharged 3 days after.

Double J stent was taken out after 4 weeks with no complications. The patient is doing well with no clinical symptoms of right kidney stone after 6 months.

Discussion and conclusion: Laparoscopic ureterolithotomy is a minimally invasive option to treat large ureteric stones not amenable to ureteroscopy. There are only few small case series describing laparoscopic ureterolithotomy for lower ureteric stones. Transperitoneal approach

gives better understanding of the anatomical landmarks particularly for lower ureteric stones. With modified technique of laparoscopic stenting, ureteral pinching and port placement strategy, lower ureteric stones can be well managed with transperitoneal laparoscopic approach.

V 06

LAPAROSCOPIC SINGLE-INCISION TRIANGULATED UMBILICAL SURGERY (SITUS) RENAL TUMORECTOMY

Artur Palmas; Tiago Oliveira; Nuno Domingues
Hospital das Forças Armadas, Lisboa

Introduction: The concept of single-incision triangulated umbilical surgery (SITUS) technique uses straight optics and instruments in a triangulated fashion via three 5mm trocars placed through an umbilical incision. This video demonstrate the feasibility of SITUS in selected exophytic renal tumors.

Material and methods: The umbilical fold was incised at three-fourth of its circumference. The pneumoperitoneum was achieve, by a 5mm camera port placed by open technique. Then a cranial 5mm port, and a caudal 5mm port were placed with a distance of 5-10cm, with the aid of two Langenbeck hooks, allowing triangulation in a familiar laparoscopic environment. Using conventional laparoscopic instruments, the intervention were executed like conventional laparoscopic transperitoneal procedures.

Conclusion: SITUS technique for selected exophytic tumors, is an attractive alternative to conventional laparoscopy and single-port surgery. It combines the common principles of traditional laparoscopy (straight instruments and triangulation) with single-port surgery (cosmesis and minimally invasiveness) resulting in adequate time and short learning curve, in a virtually scarless mode.

V 07

RETZIUS-SPARING LAPAROSCOPIC RADICAL PROSTATECTOMY

António Modesto Pinheiro; Sónia Ramos; Manuel Ferreira Coelho; Fernando Ribeiro; João Varregoso; Fernando Ferrito
Hospital Professor Dr. Fernando da Fonseca

Introduction: Radical Prostatectomy remains one of the most performed surgery by Urologists and a main treatment option for prostate cancer. Its approach can be open radical prostatectomy (ORP), laparoscopic radical prostatectomy (LRP) or robot laparoscopic-assisted radical prostatectomy (RLAP). However, in spite of the many studies worldwide available, none has shown superiority of any of the available approaches.

The Retzius-sparing or Bocciardi approach was first described in 2010 in the RLAP and its innovation was the sparing of the anterior compartment and its neurovascular bundles. The possible advantages was better urinary continence as well as better preservation of the sexual function.

Most recent studies compare this approach with the anterior or Menon approach in RLAP, and the current results support a better urinary continence achieved without worse oncological outcomes measured trough out the positive surgical margins.

Goals: In this video we shown a LRP with the Retzius-sparing.

Methods: This video was recorded in our centre using laparoscopic approach with 3D vision.

Results: In this video we show a video of a LRP of a 55 year old man with no relevant background history that was referred to the Urology appointment because of a PSA of 5,2 ng/dL. He had a suspicious digital rectal exam with a nodule on the right side and was submitted to a randomized prostate biopsy with a diagnosis of prostate adenocarcinoma Gleason 6 (3+3) on the right side only. He choose the LRP with Retzius-sparing after being informed of all available treatment options.

In this surgery after port placement, it starts with the opening of the peritoneum on the Douglas space. Afterwards both seminal vesicles are isolated and both vas deferens are sectioned. Then the Denonvilliers fascia is separated and the posterior plane is dissected in the anterograde way. The next step is to clip the lateral pedicles and isolate the lateral bundles gently. Isolation of the bladder neck is the next step, however before you complete; two cardinal stiches are placed anteriorly and posteriorly to the bladder neck, to avoid its retraction. Afterwards the anterior surfaced is separated and the urethra is sectioned. The prostate is put on an endobag and the anastomosis is done with a modified van velthoven technique with two V-lock stiches, the catheter is placed during the anastomosis. The peritoneum is approximated, a drain is put and the endobag is removed. The piece is removed and ports are closed.

The patient drain was removed 2 days after the surgery and the patient was discharged 5 days afterwards with no evidence of any complications. The catheter was removed 7 days after the surgery.

Discussion: This technique allows an anatomically correct approach to the prostate with sparing of the anterior compartment with its neurovascular bundles.

The surgical piece showed an adenocarcinoma of the prostate Gleason 6 (3+3) on the right lobe pT2 with clear surgical margins R0.

Conclusion: The Retzius-sparing approach is an oncological valid approach with possible benefit to the urinary continence and sexual function.

V 08

LAPAROSCOPIC NERVE-SPARING RETROPERITONEAL LYMPH NODE DISSECTION IN TESTICULAR CANCER

Joana Polido[1]; Tito Palmela Leitão[1]; João Lemos Almeida[1]; João Gome[1]; Carolina Borges da Ponte[1]; Afonso Castro[1]; Isabel Fernandes[2]; José Palma Reis[1]; Luís Costa[2]; Tomé Lopes[1]

[1]Urology Department, Centro Hospitalar Universitário Lisboa Norte – Hospital de Santa Maria; [2]Medical Oncology Department, Centro Hospitalar Universitário Lisboa Norte – Hospital de Santa Maria

Introduction: Retroperitoneal lymph node dissection is used for stage IIA and IIB nonseminomatous germ cell tumours with residual disease after chemotherapy or as primary treatment when tumour markers are negative. In this cases the presence of a teratoma, a chemo and radio-resistant tumour, may be suspected. The nerve-sparing technique, with identification and selective preservation of lateroaortic sympathetic trunk, preserves ejaculation without affecting oncologic safety in selected cases, even when modified templates are used. Laparoscopic approach has many advantages, as a minimally invasive technique.

Purpose: To demonstrate the laparoscopic nerve-sparing retroperitoneal lymph node dissection technique in a patient with embrional carcinoma of the testis clinical stage IIA with residual retroperitoneal disease and negative tumour markers after chemotherapy.

Methods: A 28-year-old male has been submitted to right radical orchiectomy and adjuvant chemotherapy for embrional carcinoma of the testis at 23 years old. At 27, he has done contralateral radical orchiectomy also for embryonal carcinoma stage IIB, with adjuvant 4 chemotherapy cycles. Residual left retroperitoneal disease (maximum diameter 15mm) was detected despite negative tumour markers. Laparoscopic nerve-sparing retroperitoneal lymph node dissection was offered.

Methods and results: With the patient in right decubitus position, 3 laparoscopic trocars in

midline and 1 in left iliac fossa where placed. A modified templated was used, having renal vein superiorly, internal inguinal orifice and left common iliac artery bifurcation inferiorly, ureter externally and aorta medially as its anatomical limits. Toldt line was incised and left colon and spleen mobilized for retroperitoneal access. Gerota fascia was identified. After identification and dissection of the ureter, left renal pedicle was dissected, with renal vein isolation and laqueation of ipsilateral gonadal vein. With lateroaortic sympathetic and intermesenteric plexus identification and preservation, left ganglionar area was excised. The procedure lasted for 240 minutes and estimated blood loss was 50 mL. Aspirative drain was removed on postoperative day 1. There were no complications on postoperative period and patient was discharged on day 2. At 30 days, the patient was asymptomatic with preserved ejaculation. Pathology revealed teratoma in 4 of the 8 resected lymph nodes.

Discussion/Conclusions: Retroperitoneal lymph node dissection with modified unilateral template seems to be oncologically safe in nonseminomatous testicular cancer with residual tumour less than 5cm diameter, negative tumour markers after chemotherapy and low/intermediate risk patients according to IGCCCG classification – International Germ Cell Cancer Collaborative Group. Nerve-sparing technique, despite its technical challenges, allows preservation of anterograde ejaculation in 90-100% of cases and so should be used when technically feasible. Using laparoscopic approach reduces blood loss and a faster postoperative recovery, reducing also duration of hospital stay.

V 09

LAPAROSCOPIC MESHECTOMY – A SURGICAL CHALLENGE FOR THE MODERN UROLOGIST

Joana Polido; Tito Palmela Leitão; Ricardo Pereira e Silva; Carolina Borges da Ponte; Afonso Castro; José Palma Reis; Tomé Lopes
Urology Department, Centro Hospitalar Universitário Lisboa Norte – Hospital de Santa Maria

Introduction: Using synthetic materials (mesh) for pelvic organ prolapse (POP) surgical treatment allows better time lasting functional results. However, its use has been discussed in the last few years, due to complications of multifactorial causes.

Purpose: To describe and demonstrate a case of mesh erosion and infection after laparoscopic sacrocolpopexy and its excision using also laparoscopic approach.

Materials: A case of a 68-year-old diabetic and obese female with previous total hysterectomy with right anexectomy is described. She is on clopidogrel and gingko biloba as daily medication. The patient developed a pelvic hematoma 7 days after a laparoscopic sacrocolpopexy with polypropylene mesh implantation for POP correction, as a consequence of not stopping gingko biloba medication (substance with known anticoagulant properties). For the hematoma she received medical treatment. At postoperative month 4, she developed vaginal suppuration without any identifiable mesh extrusion or pelvic abscess on the computed tomography done. Because of maintained vaginal suppuration despite the many antibiotics administered, an excision of posterior mesh component was performed using an open vaginal approach. Despite that, the suppuration persisted and a 5.5cm abscess was identified by ultrasound near the vaginal cupule. A laparoscopic excision of the remaining mesh was offered.

Methods and results: With the patient in modified lithotomy position and using 4 laparoscopic trocars, a laparoscopic transperitoneal surgical

approach was performed. At first a left oophorectomy was performed. Right after that, the vesicovaginal space was developed and dissected, hampered by the presence of extensive fibrotic tissue. The remaining mesh components, located laterally to the vaginal cupule, were carefully excised. The procedure lasted for 314 minutes and estimated blood loss was 500 mL. During postoperative period, the patient was administered a cephalosporin and metronidazol antibiotic cycle and was discharged at day 8, without complications. At postoperative day 30, she was asymptomatic, without suppuration, dyspareunia or urinary incontinence.

Discussion/Conclusion: Infection and erosion are possible complications associated with mesh implantation in pelvic reconstructive surgery. Some factors are associated with those complications, including host, surgical and prosthetic material factors. Excision of implanted mesh is a surgical challenge, mainly for all local anatomical distortion and intense fibrosis. The future use of synthetic mesh in pelvic reconstructive surgery remains uncertain, but it should be preferably reserved for highly selected patients and expert surgical centers used to deal with its implantation and also complications resolution.

THE SOUTHSIDE OF UROLOGY 2019

SIMPÓSIO DE UROLOGIA

ORGANISING COMMITTEE

President

José Miguel Leal de Carvalho

Alexandre Macedo
António Madeira
Francisco Campos
João Bastos
João Paulo Rosa
Nuno Bello
Nuno Fidalgo
Nuno Figueira
Nuno Ramos
Vanessa Metrogos

SCIENTIFIC COMMITTEE

Amaral Canelas
Ana Isabel Santos
Aníbal Coutinho
Arnaldo Figueiredo
Avelino Fraga
Cardoso de Oliveira
Carlos Rabaça
Carlos Silva
Fernando Ferrito
Fino Correia
Hélder Mansinho
Inmaculada Maldonado
Luís Campos Pinheiro
Luís Abranches Monteiro
Maria José Brito
Miguel Ramalho
Miguel Ramos
Nuno Pires
Paulo Dinis
Rui Dinis
Tomé Lopes

SPEAKERS

Alexandre Macedo
Álvaro Nunes
Amaral Canelas
Ana Isabel Santos
André Mansinho
Andrea Furtado
Aníbal Coutinho
António Madeira
António Matos
Arnaldo Figueiredo
Avelino Fraga
Belmiro Parada
Cardoso de Oliveira
Carlos Monteiro
Carlos Rabaça
Catarina Gameiro
Celso Marialva
Diogo Gonçalves
Eduardo Silva
Estêvão Lima
Fernando Calais da Silva
Fernando Ferrito
Fortunato Barros
Francisco Campos
Frederico Ferronha
Frederico Furriel
Garção Nunes
Gil Falcão
Gustavo Gomes
Hélder Mansinho
Hugo Pinheiro
Inmaculada Maldonado
Joana Alfarelos
João Bastos
João Marcelino
João Paulo Rosa
João Pina
João Varregoso
Jorge Fonseca
José Carlos Santos
José Dias
José Miguel Leal de Carvalho
José Palma dos Reis
Kris Maes
Lorenzo Marconi
Luís Campos Pinheiro
Luís Mascarenhas
Marco Dores
Maria José Brito
Miguel Lourenço
Miguel Ramalho
Miguel Ramos
Nuno Bello
Nuno Fidalgo
Nuno Figueira
Nuno Pires
Nuno Ramos
Paulo Jorge Dinis
Paulo Príncipe
Paulo Temido
Paulo Vale
Pedro Baltazar
Pedro Bargão
Pedro Galego
Pedro Monteiro
Pedro Nunes
Pedro Soares
Peter Kronenberg
Raquel João
Renato Mota
Rodrigo Ramos
Rui Dinis
Rui Formoso
Rui Prisco
Rui Sousa
Sandro Gaspar
Tiago Lopes
Tiago Neves
Tiago Oliveira
Tito Leitão
Vanessa Metrogos

THE SOUTHSIDE OF UROLOGY 2019

SIMPÓSIO DE UROLOGIA

ORGANISATION

Hospital Garcia de Orta

SERVIÇO DE UROLOGIA
DO HOSPITAL GARCIA
DE ORTA (HGO), E.P.E.

SCIENTIFIC SPONSORSHIP

Associação Portuguesa de Urologia

Ordem dos Médicos

SPONSORS

A. Menarini Portugal · ageas seguros · astellas · bioSonda · Bristol-Myers Squibb · Boston Scientific · Coloplast · Confar · ferrer · Ferring Pharmaceuticals · Ipsen · gsk · Jaba Recordati · janssen · lenitudes · Pfizer · Pierre Fabre Médicament · Roche · SPCare · tecnimede · teprel · ZSI

SECRETARIAT

admédic
CONGRESS, MEETING & EVENT MANAGEMENT

Calçada de Arroios, 16 C, Sala 3 1000-027 Lisboa
T: +351 21 842 97 10 | F: +351 21 842 97 19
E: paula.cordeiro@admedic.pt
W: www.admedic.pt