THE SOUTHSIDE OF UROLOGY 2024

3º SIMPÓSIO DE UROLOGIA

22 e 23 | novembro | 2024

Hotel TRYP Lisboa Caparica Mar

Costa da Caparica

Design: Ad Médic

Programa

Program

THE SOUTHSIDE OF UROLOGY 2024

3º SIMPÓSIO DE UROLOGIA

Sexta-feira *Friday* 22 de novembro 2024 | *November 22nd, 2024*

08:00h	Opening of the Secretariat
09:00-10:00h	**Beyond Oncology** *Chairs:* Aníbal Coutinho, João Paulo Rosa & Sara Lança
09:00-09:15h	**Non-pharmacological prevention of BPH** Margarida André
09:15-09:30h	**Cognitive dysfunction with anticholinergic medication** Luísa Moreira
09:30-09:45h	**BPH surgery champions league – Who is the winner?** Sandro Gaspar
09:45-10:00h	**From PCNL to Sepsis: Why and how?** Pedro Monteiro
10:00-10:20h	CONFERENCE **IMAGINE – Implementation of the EAU guidelines on infections** *Chairs:* Miguel Carvalho & Margarida Coelho *Speaker:* Nuno Pereira Azevedo
10:20-10:30h	**Q & A**
10:30-11:00h	Coffee break and Posters visit

11:00-12:00h	**Genes, challenges of transplantation and AI** *Chairs:* Carlos Oliveira, Pedro Nunes & Nuno Figueira
11:00-11:15h	**Genetic testing in urological cancers** Cláudia Pereira
11:15-11:30h	**GU cancer management before and after transplant** **Elevated PSA and prostate cancer** Miguel Eliseu
11:30-11:45h	**GU cancer management before and after transplant** **Renal masses and RCC** Vasco Quaresma
11:45-12:00h	**Artificial intelligence** **Bladder cancer pathological assessement** Daniel Gomes Pinto
11:45-12:00h	**Artificial intelligence** **Augmented reality for surgical planning and guidance** Rui Formoso
12:00-12:15h	**Q & A**

12:15-12:45h	**OPENING SESSION** Maria Teresa Luciano, *Presidente do Conselho de Administração da ULSAS HGO, EPE* Henrique Santos, *Diretor Clínico da ULSAS HGO, EPE* Miguel Carvalho, *Diretor do Serviço de Urologia da ULSAS HGO, EPE* Graça Pereira, *Gestora Hospitalar do ULSAS HGO, EPE* Pedro Nunes, *Vice-Presidente da Associação Portuguesa de Urologia*
13:00-14:30h	Lunch and Posters visit

14:30-15:30h	**Prostate cancer I** *Chairs:* Belmiro Parada, Nuno Ramos & Susana Carmona
14:30-14:45h	**Biopsy TR vs. TP – Interpreting the RCT's** António Pinheiro
14:45-15:00h	**Low-risk Pca: Active surveillance – How to best follow patients MRI is enough** Carolina Padilha
15:00-15:15h	**Low-risk Pca: Active surveillance – How to best follow patients Prostate biopsy is mandatory** João Pina
15:15-15:30h	**High-risk Pca – Can PSMA PET/CT spare PLND?** Andreia Bilé-Silva
15:30-15:50h	CONFERENCE **Robotic / laparoscopic surgery: Why open surgeons are still necessary ?** *Chairs:* Manuel Ferreira Coelho & Hugo Pinto Marques *Speaker:* Arnaldo Figueiredo
15:50-16:00h	**Q & A**
16:00-16:30h	Coffee break and Posters visit
16:30-17:30h	**Bladder and testis cancers** *Chairs:* Alexandre Macedo, Ricardo Leão & Pedro Bargão
16:30-16:45h	**Enhanced recovery after surgery (ERAS) in urological surgery** Luísa Alves
16:45-17:00h	**Management of complete clinical response following neoadjuvant sistemic therapy for MIBC** Manuel Oliveira
17:00-17:15h	**Current role of surgery in metastatic testicular cancer** André Pinto
17:15-17:35h	CONFERENCE **Organ-sparing radical cistectomy – A myth?** *Chairs:* Rui Prisco & João Varregoso *Speaker:* Estevão Lima
17:35-18:00h	**Q & A**

THE SOUTHSIDE OF UROLOGY 2024

3º SIMPÓSIO DE UROLOGIA

Sábado *Saturday* **23 de novembro 2024** | *November 23rd, 2024*

08:00h	Opening of the Secretariat
08:30-09:15h	**3 best posters and videos – Podium presentation** *Chairs:* Frederico Ferronha, João Marcelino & Jorge Fonseca
09:15-10:30h	**Prostate cancer II** *Chairs:* Ana Isabel Santos, Tito Leitão & Hélder Mansinho
09:15-09:30h	**Prostate cancer in transgender women** Paulo Azinhais
09:30-09:45h	**Advances in robotic prostatectomy** Frederico Teves
09:45-10:00h	**PCa: Doublets or triplets – Seleting the optimal treatment** André Mansinho
10:00-10:15h	**PSMA – Targeted imaging and radioligand therapy** **Nuclear medicine physician's perspective** Inês Cardoso Ferreira
10:15-10:30h	**PSMA – Targeted imaging and radioligand therapy. Urologist perspective** Mariana Medeiros
10:30-10:40h	**Q & A**
10:40-11:10h	Coffee break

11:10-11:30h	**CONFERENCE** **Robotic surgery – Experience of a centenary urological department** *Chairs:* Miguel Carvalho & Fernando Ferrito *Speaker:* Avelino Fraga
11:30-12:15h	**Penile cancer** *Chairs:* Tiago Oliveira, Paulo Jorge Dinis & Rodrigo Ramos
11:30-11:45h	**Role of sentinel node technique** Isaac Braga
11:45-12:00h	**Robotic inguinal lymph node dissection** David Subirá
12:00-12:15h	**Organ sparing treatment options** Celso Marialva
12:15-12:35h	**CONFERENCE** **Dealing with consequences of radical treatment of GU cancers** *Chairs:* Ricardo Pereira e Silva & Margarida Freitas *Speaker:* Raquel Botelho Costa
12:35-13:00h	**CLOSING CEREMONY** *Chair:* Miguel Carvalho *Panel:* Alexandre Macedo, João Paulo Rosa, Luísa Moreira, Margarida André, Marta Vasconcelos & Nuno Figueira

Posters

PO 04

MANAGEMENT OF LOCALLY ADVANCED UPPER TRACT UROTHELIAL CANCER: EXPERIENCE OF A TERTIARY CENTRE

Frederico Portugal Gaspar[1]; Filipe Lopes[1]; orge Correia[2]; João Carvalho[2]; Isaac Braga[2]; Rui Freitas[2]; Vítor Silva[2]; José Sanches Magalhães[2]; Francisco Lobo[2]; António Morais[2]
[1]Centro Hospitalar de Lisboa Ocidental, EPE / Hospital Egas Moniz; [2]IPO Porto

Introduction: Upper tract urothelial cancer (UTUC) is a rare but aggressive malignancy, with a high proportion of locally advanced disease at presentation. Surgical management of locally advanced UTUC is still controversial with older series favouring open radical nephroureterectomy but more recent works contesting this original notion.

Goals: We aim to analyse the surgical management of locally advanced UTUC in our institution and try to ascertain if a minimally invasive approach is equivalent to open radical nephroureterectomy.

Methods: We performed a retrospective study by reviewing the clinical records of patients submitted to radical nephroureterectomy in our centre for locally advanced UTUC (defined as pT3/pT4 and/or pN+) between January 2018 and June 2023. 32 cases were included for analysis and divided according to surgical approach: i) open radical nephroureterectomy (ORNU) (group 1; n=12); ii) laparoscopic radical nephroureterectomy (LRNU) (group 2; n=20).

Demographics, clinical and tumour variables at presentation, pathological details and outcomes, both oncological and perioperative, were collected and compared.

Results: We observed an association favouring a laparoscopic approach in older patients (69.7±3.2 vs 77.7±1.9; p=0.028). We found no other differences between the groups regarding tumour characteristics at presentation namely size greater than 2 cm, focality, hydronephrosis, urine cytology. All cases were classified as high risk according to EAU classification. Also, there were no significant differences between the groups regarding pathological characteristics, such as T stage (p=0.204), N stage (p=0.696), presence of Carcinoma in situ (p=0.379) or presence of a pathological subtype (p= 0.130).

Regarding perioperative outcomes, we only observed a trend favouring the laparoscopic approach for fewer major complications (11.1% vs 5.6%; p=0.1) and a shorter hospital stay (p=0.053).

Median follow-up was 19 months (Interquar-

tile range-22 months) and similar amongst the groups (p=0.646). We observed a lower rate of local recurrence in LRNU (58.3% vs 11.1%; p=0.013) and a trend for a better survival rate in LRNU (18.2% vs. 57.9%; p=0.057). Oppositely, bladder recurrence (11.1% vs. 22.2%) and distant recurrence (81.8% vs 50%) were similar between populations. Disease-free survival, assessed by log-rank test, showed a trend favouring LRNU (p=0.088); Overall survival was not statistically different between surgical approaches.

Discussion/Conclusions: Our results challenge the superiority of open radical nephroureterectomy and suggest that, in line with more recent works, laparoscopic radical nephroureterectomy may be equally safe as the open approach in locally advanced UTUC.

PO 05

HISTOLOGICAL SUBTYPES ASSOCIATED WITH WORSE PROGNOSIS IN UPPER TRACT UROTHELIAL CANCER

Frederico Portugal[1]; Filipe Lopes[1]; Jorge Correia[2]; João Carvalho[2]; Isaac Braga[2]; Rui Freitas[2]; Vítor Silva[2]; José Sanches Magalhães[2]; Francisco Lobo[2]; António Morais[2]

[1]Centro Hospitalar de Lisboa Ocidental, EPE / Hospital Egas Moniz; [2]IPO Porto

Introduction: Upper tract urothelial cancer (UTUC) is an infrequent and aggressive malignancy. In approximately 25% of the cases, a divergent differentiation occurs, resulting in a different histological subtype (HS). The presence of these different subtypes has been associated with worse oncological outcomes.

Goals: We aim to compare a population of UTUC patients with HS with patients with pure Urothelial Carcinoma (UC) histology and to ascertain if there are differences regarding oncological outcomes.

Methods: We performed a retrospective analysis of all patients submitted to radical nephroureterectomy in our centre for non-metastatic UTUC between January 2018 and June 2023. 79 cases were identified and divided according to the presence of HS: i) different subtype present (group 1, n=21 [26.6%]); ii) Conventional UC (group 2, n=58).

Demographics, clinical and tumour variables at presentation, pathological details and oncological outcomes were compared. Metastasis-free survival (MFS) and overall survival (OS) were also analysed after stratification for muscle-invasive or locally advanced disease status (≥pT2 and/or pN+) and in a multivariable Cox regression model.

Results: The most frequent subtype was squamous differentiation in 61.9% (n=13), followed by glandular differentiation and micropapillary UC (3 cases each). We found no differences in demographics variables, namely gender, age or previous UC history between groups. We also found no differences regarding tumour characteristics at presentation such as dimension greater than 2cm, focality, hydronephrosis or urinary cytology. There was no association between the presence of a HS and muscle-invasive or locally advanced disease (71.4% vs 55.2%; p= 0.210).

Median follow-up was 21 months (Interquartile range - 21 months) and similar amongst the groups (p=0,321). We observed a higher rate of metastization in the HS population (50.0% vs 20.0%; p= 0.018). We also observed a trend for a higher rate of local recurrence (28.6% vs 9.3%; p= 0.063) and higher mortality (50% vs 26.3%; p=0.060) in this group.

The presence of a HS was associated with worse MFS (Hazard Ratio [HR]: 3.050 95% Confidence Interval [CI] 1.286-7.235; p=0.011) and a trend towards worse OS (HR 2.154 95%CI 0.965-4.809; p=0.061). After stratification for ≥pT2 and/or pN+ disease, we continued to observe an association between the presence of HS and worse MFS (HR 2.697 95%CI 1.113-6.539; p=0.028). On multivariable Cox regression analysis, presence of HS

showed an association with worse MFS (HR: 2.840 95% CI 1.122-7.189; p=0.028) but not with worse OS (p=0.189).

Discussion/Conclusions: The prevalence of a different histological subtype in our cohort is concordant with the current literature. In line with other studies, our results also suggest worse oncological outcomes in this population. The finding of worse MFS even after stratification for ≥pT2 and/or pN+ disease and in multivariate analysis, suggests that the presence of a HS could be an independent factor of worse prognosis. The implications of histological subtypes in UTUC should then be further studied, namely the eligibility and efficacy of adjuvant treatments.

PO 06

A TOUGH NUT TO CRACK: A CASE REPORT

André Manuel Jorge Pita; Eduardo Felício; Guilherme Bernardo; Filipe Gaboleiro; Sara Duarte; Pedro Bargão; Fernando Ferrito; Sónia Ramos
Hospital Prof. Doutor Fernando Fonseca

Introduction: Nutcracker syndrome (NCS), first described by Grant, occurs when the left renal vein (LRV) is compressed between the aorta and superior mesenteric artery, resembling a nut being squeezed in a nutcracker. NCS is rare and often asymptomatic, but increased venous pressure may cause hematuria due to the formation of collateral veins. Symptoms can include left flank pain, left sided varicocele, pelvic congestion, chronic fatigue, orthostatic proteinuria, and gastrointestinal issues. Diagnosis is often delayed, confirmed by imaging, and treatment depends on symptom severity. Interventions are considered for persistent symptoms, hematuria, severe pain, or renal dysfunction. This case highlights the need for collaboration among nephrologists, radiologists, and urologists in diagnosis and treatment.

Objective: This report presents a case of Nutcracker syndrome and reviews clinical evidence on its diagnosis and management.

Materials and methods: A 22-year-old female was admitted in March 2024. Her clinical history, symptoms, and imaging studies were thoroughly reviewed.

Results: The patient presented with intermittent macroscopic hematuria and left flank pain lasting for three months. Repeated urine cultures were negative. Gross hematuria persisted, and noncolicky pain worsened with physical activity and prolonged standing. Her medical history included a prior pyelonephritis admission. Physical examination showed a tall and thin body habitus. Laboratory tests showed moderate anemia (hemoglobin: 8 mg/dl) and non-glomerular proteinuria. Cystoscopy revealed bleeding from the left ureteral orifice. Urinary red cell morphology indicated 90% isomorphic red cells. No casts were present, and urine cytology was negative for malignancy. The patient was admitted to the urology ward for continuous bladder irrigation and further evaluation of hematuria. A CT urogram was inconclusive, with a normal aorto-mesenteric angle of 60º (normal range: 38-65º). A Doppler ultrasound was suggested by the Nephrology department, which revealed a dilated LRV (12mm) and a narrowed posterior segment (2mm), resulting in a high compression ratio of 6 and an elevated peak systolic flow (143 cm/s), consistent with NCS. A compression ratio above 2.25 is highly indicative of NCS. Although conservative management was initially considered, persistent hematuria and anemia prompted the placement of a venous stent by Interventional Radiology. The patient had an uncomplicated postoperative course, with complete resolution of pain and hematuria at one- and three-month follow-up.

Discussion: NCS tends to affect women, particularly those with an asthenic body type. This case emphasizes the importance of considering NCS in young patients presenting with flank pain and hematuria, especial-

ly when initial imaging is normal, which can delay diagnosis. The case also highlights the importance of utilizing alternative diagnostic modalities, such as Doppler ultrasound, when standard imaging is inconclusive. Furthermore, it underscores the value of interdisciplinary collaboration in managing NCS. Renal vein stenting provides promising relief in select cases, although further research is needed to determine long-term outcomes and the most effective management strategies, particularly for younger patients. Early diagnosis and timely intervention can significantly improve the quality of life for symptomatic individuals.

PO 07

BCG: QUANDO O TRATAMENTO É A CAUSA DO PROBLEMA!

Pedro Serrano; Bárbara Oliveira; Pedro Barros; Marco Dores; Anibal Coutinho
Centro Hospitalar do Algarve, EPE / Hospital de Faro

Introdução: A instilação vesical do Bacillus Calmette-Guérin (BCG), estirpe viva atenuada de Mycobacterium bovis é usado em adjuvância no tratamento da neoplasia vesical de alto grau não invasiva. Geralmente é bem tolerado podendo, raramente, levar a complicações locais e sistémicas graves. Os fatores de risco incluem a presença de lesões tumorais em atividade na mucosa da bexiga, imunossupressão e idade avançada.

A infeção por M. bovis (BCG) pode disseminar-se localmente a partir da bexiga para outras estruturas do trato génito-urinário. Tais infeções incluem ulceração granulomatosa do pénis, prostatite, epididimite, obstrução ureteral e abscesso renal. A descontinuidade da mucosa da bexiga após a cirurgia pode permitir a propagação do micro-organismo para a cavidade pélvica ou peritoneal.

Objetivo: Reportar o caso de uma orqui-epididimite secundária a instilação com BCG.

Métodos: Os dados relativos ao caso clínico foram colhidos a partir do processo hospitalar.

Resultados: Descreve-se o caso de um homem de 62 anos, com antecedentes de adenocarcinoma da próstata (tratado com radioterapia e bloqueio hormonal há 9 anos), hipertensão arterial e diabetes mellitus.

Há 6 anos, por LUTS de esvaziamento, refratários ao bloqueio alfa-adrenérgico, recorreu ao Hospital Privado, tendo sido submetido a resseção trans-uretral da próstata e de lesão suspeita a nível da bexiga, achado intra-operatório (RTUP/RTUV).

O estudo anátomo-patológico revelou "lesões compatíveis com hiperplasia fibroglandular e lesão urotelial de alto grau, com invasão do tecido conjuntivo (pT1)".

Após nova RTU do leito, foi proposto para imunoterapia vesical com BCG, calendarizadas segundo o protocolo local.

Durante a indução, por quadro de orquite supurativa sem resposta à antibioticoterapia instituída, foi submetido orquidectomia simples, tendo o estudo anátomo-patológico revelado a presença de achados sugestivos de orquite crónica associada a granulomas.

Em conjunto com a infeciologia admitiu-se o diagnóstico, tendo sido suspensas as instilações com BCG e iniciado tratamento tuberculostático. À reavaliação o doente apresenta-se assintomático, sem outras intercorrências a salientar no seguimento oncológico.

Conclusão: Neste relato, apresenta-se o caso de um doente do sexo masculino, sem história prévia de tuberculose, que recorre ao hospital com quadro de orquite supurativa após o tratamento com instilação intravesical de BCG. Após cuidadosa investigação, assumiu-se o diagnóstico de orquite, secundária a disseminação do BCG usado no tratamento do seu carcinoma da bexiga.

Os doentes com infeção por M. bovis secundária à terapia intravesical são tratados com os mesmos fármacos usados na infeção por Mycobacterium de outras origens. O regime ideal e

a duração do tratamento são incertos e devem envolver um especialista com experiência.
O tratamento cirúrgico está indicado no caso da formação de abcesso ou obstrução do trato génito-urinário. Em quadros de orquite persistente e refratária à terapêutica médica, a orquidectomia deve ser realizada, quer para controlo de foco quer para alívio sintomático. Não existem descritas, na bibliografia, intervenções comprovadas para prevenir complicações infeciosas associadas à administração intravesical de BCG, daí a relevância deste caso para a manutenção de um elevado nível de alerta caso estas surjam.

PO 08

CHARACTERIZING UROPATHOGENIC FLORA IN URINARY STONE PATIENTS FOR OPTIMAL ANTIBIOTIC MANAGEMENT

Miguel Valente Fernandes; Maria Castilho; João Melo; Miguel Miranda; Sérgio Pereira; Carla Santos; José Palma Dos Reis
Centro Hospitalar de Lisboa Norte, EPE / Hospital de Santa Maria

Introduction and objective: Urinary tract infections (UTIs) are a common concern in patients with urolithiasis, as obstructing stones can facilitate bacterial colonization and increase the risk of infection. The presence of bacteria in urine cultures prior to endoscopic lithiasis treatment is clinically significant, as it can influence both the choice of preoperative antibiotics and the overall treatment strategy. Understanding the epidemiology of bacteria in this context is crucial for reducing perioperative infectious complications, such as sepsis or pyelonephritis, which can occur during or after stone removal procedures. This study aims to assess the prevalence and patterns of bacterial pathogens in urine cultures from lithiasic patients before undergoing endoscopic treatment, providing insights into antibiotic resistance profiles and guiding clinical management strategies.

Materials and methods: We retrospectively evaluated all patients who underwent endoscopic stone treatment at our institution between September 1, 2022, and August 31, 2024. All patients who had preoperative urine cultures (UC) performed at our center were included. Patients who only had JJ stent placement or failed attempts at percutaneous access were excluded. Positive bacterial cultures and their susceptibility to different antibiotics were analyzed and reviewed at our center by a specialized infectiologist.
Results: There were 461 endoscopic stone treatment procedures over these 24 months. This included 177 ureterorenoscopies (URS), 258 retrograde intrarenal surgeries (RIRS), 15 endoscopic combined intrarenal surgeries (ECIRS), and 11 bladder stone treatments. Preoperative UC from 41 patients were conducted outside our center and were excluded from this analysis, leaving 189 males and 231 females with a mean age of 55.7 years (± 12.1). Negative UC were present in 264 cases, 119 had positive urine cultures, and 35 had contaminated urine cultures.
Escherichia coli was the most frequently isolated agent, appearing in 31.9% of cases, followed by *Klebsiella pneumoniae* in 26.1%, *Proteus mirabilis* in 16.8%, *Enterococcus faecalis* in 15.1%, *Pseudomonas aeruginosa* in 5.9%, *Streptococcus* in 1.7%, *Candida* in 1.7%, *Morganella morganii* in 1.7%, and *Serratia marcescens* in 1.7% (all from urine cultures with more than one bacterium). Only one positive UC was found for each of the following bacteria: *Staphylococcus epidermidis*, *Staphylococcus saprophyticus*, and *Enterococcus faecium*. For easier readability the susceptibilities and resistances to different classes of antibiotics of the most common agents are presented in Table 1(Gram -) and Table 2 (Gram +).
Conclusions: This study is crucial for understanding the bacterial flora in our urology

stone patients, which has direct implications for managing infections and preventing complications. By cooperating with the infectiology department, we are now tailoring antibiotic regimens for prophylaxis during urological procedures. This allows for a more judicious selection of antibiotics, reducing reliance on broad-spectrum options and supporting antibiotic stewardship efforts. This approach helps combat antibiotic resistance, a growing concern in healthcare. In cases where urosepsis develops, having precise information on the microbial flora enables rapid and effective treatment with the most appropriate agents.

PO 09

CHANGES IN URINARY STONE COMPOSITION OVER TEN YEARS MPACTING UROLITHIASIS CARE

Miguel Valente Fernandes; João Melo; Maria Castilho; Joana Rodrigues; Miguel Miranda; Álvaro Nunes; Sérgio Pereira; José Palma Reis
Centro Hospitalar de Lisboa Norte, EPE / Hospital de Santa Maria

Introduction and objective: Understanding the composition of urinary stones in patients with urolithiasis is crucial for developing effective prevention and management strategies. Stone composition offers insights into the underlying metabolic, dietary, and environmental factors contributing to stone formation, allowing clinicians to tailor interventions more precisely. Variations in stone composition over time can reflect shifts in risk factors, including dietary habits, lifestyle factors, and healthcare practices, as well as the impact of evolving therapeutic approaches.
This study aims to compare the composition of urinary stones from patients treated over the past two years with data from a decade ago, highlighting potential changes in epidemiological trends and informing improvements in personalized care and preventative strategies for urolithiasis.

Materials and methods: We retrospectively evaluated two cohorts of patients who underwent endoscopic stone treatment at our institution: the first cohort from April 2008 to March 2013 (Group A) and the second from September 1, 2022, to August 31, 2024 (Group B). All urinary stones were analyzed using Fourier-transform infrared (FTIR) spectroscopy at our center. Patients were screened for age, gender, stone composition, and the number of components in each stone.
Results: Group A and Group B included 502 and 88 patients, respectively, with a mean age of 51.7 and 55.2 years, and a predominance of male patients (60% in Group A vs. 51% in Group B).
Stones with a single mineral component were found in 14.1% of Group A versus 29.5% of Group B; two components in 72.8% vs. 64.7%; three components in 21.5% vs. 58%; and four components in 2.0% vs. 0%.
In the components analyzed ten years ago, we observed calcium oxalate in 96.0%, calcium phosphate in 60.8%, uric acid in 23.9%, struvite in 20.1%, ammonium urate in 4.6%, calcium carbonate in 3.8%, and cystine in 1.8%. In the recent cohort, 41.8% contained calcium oxalate, 27.6% calcium phosphate, 9.2% uric acid, 5.9% brushite, 3.3% struvite, 2.6% protein matrix, 2.0% cystine, and 1.3% calcium carbonate.
Conclusion: This study reveals significant changes in urinary stone composition over the past decade, likely reflecting shifts in dietary habits, lifestyle factors, and healthcare practices. Notably, the recent cohort showed a lower prevalence of calcium oxalate and calcium phosphate stones, previously predominant, and an increase in less common components such as brushite and protein matrix. These findings underscore the importance of regularly monitoring stone composition trends to refine preventative and therapeutic strategies in urolithiasis management.

PO 10

SÍNDROME DE ZINNER: ACHADO INCIDENTAL!

Pedro Serrano
Centro Hospitalar do Algarve, EPE / Hospital de Faro

O síndrome de Zinner é uma anomalia congénita rara do ducto de Wolff, constituída por ausência renal unilateral, obstrução do ducto ejaculatório ipsilateral e quisto da vesícula seminal. Existem pouco mais de 200 casos relatados a nível internacional.

Um defeito da embriogénese do botão uretérico entre a 4ª e a 13ª semana de gestação está na génese desta patologia.

Neste relato, descrevemos o caso clínico de um homem de 56 anos, seguido em consulta de doenças auto-imunes, que foi referenciado à consulta de Urologia por um achado incidental numa ecografia abdominal, sem outro historial médico ou cirúrgico. Na ressonância magnética (RMN), foi melhor caracterizada a agenesia renal direita, obstrução do ducto ejaculatório ipsilateral e o quisto da vesícula seminal ipsilateral, salientando-se um pequeno nódulo no interior da imagem quística. O doente apresentava-se totalmente assintomático. Os achados apoiaram o diagnóstico da síndrome de Zinner, pelo que se optou por controlo imagiológico periódico da lesão suspeita. A ecografia abdominal (US), tomografia computadorizada (CT) e ressonância magnética (RM), são os exames imagiológicos que sustentam o diagnostico, sendo que o último corresponde ao exame goldstandart. O síndrome de Zinner deve ser considerado como um diagnóstico diferencial em doentes do sexo masculino com agenesia renal unilateral e massas pélvicas quísticas. O tratamento em doentes assintomáticos normalmente passa por uma estratégia conservadora e deve ser considerada a fertilidade do doente. Em doentes com quistos sintomáticos que não respondem ao tratamento conservador ou cujos quistos são maiores que 5 cm de diâmetro, recomenda-se a intervenção cirúrgica (cirurgia aberta ou laparoscópica e dilatação do balão do ducto ejaculatório).

Palavras-chave: Urologia; Sindrome de Zinner; agenesia/displasia renal; ducto de Wolff; Cirurgia via laparoscópica ou via aberta.

PO 11

UROSTENT STUDY: A PROSPECTIVE, RANDOMIZED COMPARISON OF CONVENTIONAL STENTS VS PIGTAIL SUTURE STENTS

Rui Caceiro; Pedro Baltazar; Ana Meireles; Patricia Pereira; Alexia Gomes; Miguel Brito Lança; Pedro Silva; João Amilcar Cunha; Miguel Gil; João Guerra; Luís Campos Pinheiro
Centro Hospitalar de Lisboa Central, EPE / Hospital de Santa Marta

Introduction: The double-pigtail ureteral stent has become a fundamental tool in urology for maintaining ureteral patency in various clinical situations. However, despite its effectiveness, the stent often causes significant discomfort, collectively referred to as “stent syndrome.” This syndrome affects over 80% of patients, with symptoms including irritative voiding, pain and hematuria. To mitigate these adverse effects, the JFIL pigtail suture stent (PSS) was developed, featuring a thinner suture thread at the lower end to reduce bladder irritation while maintaining the stent’s functionality. Although initial results are promising, comprehensive clinical trials are needed to confirm the PSS’s efficacy, safety, and potential to improve patients’ quality of life, potentially positioning it as a superior alternative to traditional stents. Objectives: This study aims to compare clinical outcomes and renal function between conventional ureteral Stents (CS) and PSS and assess quality of life and symptom presence using the Ureteric Stent Symptom Questionnaire (USSQ). **Material and methods:** This was a prospec-

tive, randomized cohort study involving two groups of patients receiving either CS or PSS between February and June 2024. Participants were followed for one month post-stent placement, with data collected on clinical improvement, renal function, and stent-related symptoms. Quality of life was assessed using the Ureteric Stent Symptom Questionnaire (USSQ). The primary outcomes included clinical improvement, renal function, and symptom presence. Statistical analyses were conducted to compare outcomes between the two groups. Exclusion criteria included distal ureter obstruction, proximal obstruction by calculi less than 10mm, absence of a CT scan within the last 3 months, and solitary kidney.

Results: A total of 32 patients were enrolled, with 17 receiving conventional ureteral stents (CS) and 15 receiving pigtail suture stents (PSS). No postoperative complications occurred in these patients. Using the USSQ, the PSS group had significantly better results in the Urinary Symptoms Index score, Pain Index score, Pain Intensity, and General Health Index score of the questionnaire. Among patients who had previously received a CS and later a PSS, the PSS scored significantly better in the Urinary Symptoms Index score and the "Feeling about Stenting in the Future" score. There were no significant differences in the results between gender and age groups.

Discussion/Conclusions: The PSS demonstrates clear advantages over CS, particularly in reducing symptoms associated with "stent syndrome," such as urinary discomfort and pain. In this research, the group treated with PSS reported an overall improvement in quality of life. Notably, the patients who have tried both types of stents prefer PSS, citing greater comfort and reduced anxiety about future stenting procedures. The absence of postoperative complications in either group and the lack of significant differences across gender or age further support the safety and efficacy of the PSS. While the findings from the present study are optimistic, the PSS still faces two significant obstacles. It is important to remember that it has strict indications and is not safe in cases of distal ureteral obstruction or small proximal obstructive lithiasis - due to the risk of stone migration. Additionally, since evidence is currently limited, future large-scale studies will be crucial in confirming the long-term benefits and broader clinical applicability of the PSS, as well as validating its clinical indications and limitations.

PO 12

PREDICTORS OF PATHOLOGICAL UPGRADING IN ISUP GRADE GROUP 1 PROSTATE CANCER

Miguel Valente Fernandes[1]; Miguel Miranda[1]; Kayann Hayek[2]; Luisa Alves[2]; Tomas Moretti[2]; Adalgisa Guerra[2]; João Cassis[2]; Kris Maes[1]
[1]Centro Hospitalar de Lisboa Norte, EPE / Hospital de Santa Maria; [2]Hospital da Luz Lisboa

Introduction: Prostate cancer is one of the most diagnosed malignancies in men and remains a significant cause of morbidity and mortality worldwide. The arrival of prostate-specific antigen (PSA) screening has revolutionized early detection, with more men being diagnosed with clinically localized disease. For low-risk prostate cancer (PCa), current guidelines recommend active surveillance (AS). However, concerns remain about the potential for misclassification of patients who may harbor more aggressive disease, underscoring the importance of accurate grading at diagnosis for proper risk stratification. One significant issue is pathological upgrading after radical prostatectomy (RP).

This study aims to evaluate contemporary rates and risk factors for pathological upgrading after robotic-assisted radical prostatectomy (RARP) in patients with the lowest ISUP grading group, as well as to report on the functional outcomes associated with treat-

ment in this patient cohort.

Materials and Methods: We reviewed prospectively maintained databases of 474 patients who underwent robotic-assisted radical prostatectomy (RARP) for localized PCa between July 2020 and July 2024 at a single institution. This study focused on 81 patients with ISUP 1 based on biopsy and multiparametric MRI (mpMRI). Data on preoperative parameters, such as PSA, PSA Density (PSAD), digital rectal examination (DRE), PI-RADS score, biopsy technique, and postoperative outcomes such as pathological upgrading, surgical margins, continence, and potency rates were assessed. Continuous variables were expressed as medians and interquartile range, while categorical variables were presented as percentages. Statistical comparisons were made using chi-squared and t-tests.

Results: Among the 81 ISUP 1 patients, the median age was 63 years, with a PSAD of 0.10 ng/mL/cm³. Pathological upgrading occurred in 69.1% of patients, with 96.2% upgrading to ISUP 2 and 3.8% to ISUP 3. Higher PSAD, PSA, clinical T stage, imaging-derived T stage, and lesion size on mpMRI were significant predictors of upgrading. Upgrading rates based on PI-RADS classification were as follows: 53.84% for PI-RADS ≤3, 70.59% for PI-RADS 4, and 76.48% for PI-RADS 5. Although there was a trend toward higher upgrading rates with higher PI-RADS scores, this did not reach statistical significance. However, age, BMI, prostate volume, and the time interval from biopsy to surgery did not significantly influence upgrading rates. Functional outcomes were favorable, with 84.5% of patients achieving complete continence and 82.8% reporting acceptable erectile function at 6 months. Positive surgical margins were reported in 6.2% of cases, and there was only one case of biochemical recurrence.

Conclusion: This study challenges the assumption that active surveillance is universally appropriate for all ISUP 1 prostate cancer patients. Given the high rates of pathological upgrading and favorable functional outcomes after RARP, careful patient selection is essential when considering AS. RARP offers effective oncologic control with minimal impact on continence and sexual function, making it a viable treatment option for select patients at higher risk of upgrading.

PO 13

TESTICULAR TUMOR IN ADRENOGENITAL SYNDROME: DIAGNOSTIC CHALLENGES AND MULTIDISCIPLINARY MANAGEMENT

Pedro Gabriel Inglês Gomes Silva
Centro Hospitalar de Lisboa Central, EPE / Hospital de Santa Marta

Adrenogenital syndrome (AGS) is a rare disorder characterized by impaired steroid biosynthesis and testicular tumors that presents unique diagnostic and therapeutic challenges. This case study delves into the clinical journey of a 31-year-old male patient with AGS who was diagnosed with a testicular tumor. The patient initially presented with infertility, but further investigation revealed a palpable testicular mass and bilateral nodules on testicular ultrasound, raising concern for testicular malignancy. Through a multidisciplinary decision, a radical right orchiectomy was performed.

After this intervention, the histopathological examination confirmed the testicular tumor of AGS. Staging CT highlighted obturator nodes and pulmonary micronodules. Given the rare incidence of AGS tumors and their benign manifestations, after multidisciplinary and specialized discussion, the patient was kept in active surveillance. So far the patient has been stable and without further manifestations of AGS after endocrinologic referral.

This case highlights the intricate interplay between AGS and testicular tumors, emphasiz-

ing the need for a multidisciplinary approach. Diagnostic challenges included distinguishing between benign and malignant testicular lesions, assessing hormonal imbalances, and managing comorbidities associated with AGS. Treatment, on the other hand, involved surgical excision of the tumor, hormone replacement therapy, and long-term follow-up to monitor hormonal and oncological outcomes.
The case study underscores the importance of close collaboration between endocrinologists, urologists and pathologists to ensure a comprehensive evaluation and tailored management strategy. It also sheds light on the intricate nature of AGS when complicated by testicular tumors, highlighting the need for a holistic approach to diagnosis, treatment,and long-term care.
This report provides valuable insights for clinicians encountering similar scenarios, highlighting the importance of a holistic and multidisciplinary approach in managing complex disorders.

PO 14

CHALLENGES OF SURGICAL MANAGEMENT OF PATIENTS WITH AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE

Pedro Gabriel Inglês Gomes Silva
Centro Hospitalar de Lisboa Central, EPE / Hospital de Santa Marta

Autosomal dominant polycystic kidney disease (ADPKD) is one of the most common genetic kidney disorders, marked by the progressive enlargement of cysts, which can impair kidney function and lead to end-stage renal disease (ESRD). Complications such as cyst infections, hemorrhage, and pain are common in the advanced stages of ADPKD. Recurrent cyst infections, particularly in patients already on dialysis, may necessitate surgical intervention, including nephrectomy, to prevent further complications.
Bilateral nephrectomy can be indicated in patients with recurrent cyst infections unresponsive to medical treatment. This case series describes two patients with ADPKD who underwent bilateral nephrectomies due to cyst infections, emphasizing their surgical challenges. A 56-year-old female with ADPKD and ESRD on hemodialysis presented with recurrent, severe cyst infections despite in hospital antibiotic therapy and biliary duct compression resulting in jaundice. Imaging revealed multiple infected cysts and, after multidisciplinary discussion, a bilateral nephrectomy was recommended. Intraoperative challenges included managing the large cystic kidneys and adhesions. The surgery was successful, and the patient recovered fully, with resolution of infection and no further complications. A 49-year-old male with a history of ADPKD, ESRD and recurrent cyst infections, unresponsive to medical treatment with a prolonged hospitalization period, also underwent bilateral nephrectomy. The surgery was complicated by the size of the polycystic kidneys and significant adhesions. However, the procedure was completed successfully with no intraoperative complications. The patient had an uneventful postoperative recovery and remained infection-free during follow-up. Bilateral nephrectomy in patients with ADPKD complicated by recurrent cyst infections poses significant surgical challenges, including managing enlarged kidneys and adhesions, and maintaining intraoperative stability. Despite these complexities, both patients in this case series achieved favorable outcomes with resolution of infection and stable postoperative courses. These cases underscore the importance of a multidisciplinary approach in managing complex ADPKD cases, particularly when surgical intervention is necessary to improve patient quality of life.

PO 15

ACTIVE SURVEILLANCE IN PATIENTS WITH LOW-RISK PROSTATE CANCER – THE EXPERIENCE OF A TERTIARY CENTER

Miguel Lança; João Ferreira Guerra; Miguel Pinho Gil; Nguete Veloso; João Amílcar Cunha; Pedro Gabriel Silva; Patrícia Pereira; Ana Meireles; Rui Caceiro; Aléxia Gomes; Felipe Freire; Pedro Miguel Baltazar; João Magalhães Pina; Luís Campos Pinheiro
Hospital de São José

Introduction: Active surveillance aims to avoid unnecessary treatment in men with localized prostate cancer who do not require immediate intervention, through regular follow-up programs that include physical examinations, PSA measurements, prostate MRI, and serial prostate biopsies, while simultaneously determining the appropriate time to initiate active therapy for patients who reach predefined thresholds indicative of potentially fatal but still curable disease, considering each patient's life expectancy. The recommended protocols for monitoring this patient population are diverse and highly rigorous, making absolute compliance challenging.

Goals: To characterize the population of prostate cancer patients undergoing active surveillance at a tertiary care center and factors associated with need for curative treatment during follow up.

Methods: Patients with prostate cancer who were under active surveillance at our center during the period from 2020 to 2023 were selected. Clinical, laboratory, and histopathological data were collected retrospectively through a review of the patients' medical records. Univariate and multivariate analysis were done to analyze factors associated with need for curative treatment.

Results: 116 men with a mean age at diagnosis of 66.5±8.8 years were followed up in active surveillance consultations over a highly variable period (from 226 days to 19 years). The median PSA value and PSA density at diagnosis were 5.2 (IQR 0.3-18.3) and 0.09 (IQR 0.003-2.371), respectively. The diagnosis of prostate cancer was made through a double sextant transrectal/transperineal biopsy in 52 patients and through a transperineal fusion biopsy in 44 patients. In the remaining 20 patients, the diagnosis was made by histopathological analysis of specimens from benign prostatic surgery (open and endoscopic). The most frequently observed Gleason score in the diagnostic biopsy was 3+3 in 94% of cases and 3+4 in 6%. The confirmatory biopsy revealed a Gleason score of 3+3 in 50% of cases. An upgrade in the Gleason score was observed in 15.5% of cases during the confirmatory biopsy or subsequent protocol biopsies (11.2% to 3+4, 3.4% to 4+3, and 0.9% to 4+4), with 13.8% of patients undergoing curative treatment (radical prostatectomy and external beam radiation therapy combined with hormone therapy). In 7 patients, the strategy was changed to watchful waiting due to life expectancy. Patients with a confirmation biopsy at diagnosis with a Gleason score higher than 3+3 and a higher difference between maximum PSA value during follow up and PSA value at diagnosis have a higher probability of need for a curative treatment ($p=0.006$ and $p<0.001$, respectively), even adjusted for PSA value at diagnosis ($p=0.033$ and $p=0.001$, respectively).

Conclusions: Our experience supports earlier findings that active surveillance is a safe management approach for men with low-risk prostate cancer. This strategy should be strongly advocated for these patients, as it mitigates treatment-related complications while maintaining effective cancer control. Patients with a Gleason score higher than 3+3 at diagnosis and a higher difference between maximum PSA value during follow up and PSA value at diagnosis should be kept under closer surveillance due to higher probability

of need for curative therapy. More studies are needed to corroborate these findings.

PO 16

BLADDER PERIVASCULAR EPITHELIOID CELL TUMOR (PECOMA) WITH UNCOMMON IMMUNOHISTOCHEMICAL STAINING

Miguel Lança; João Cabral Pimentel; João Ferreira Guera; Miguel Pinho Gil; Nguete Veloso; João Amílcar Cunha; Pedro Gabriel Silva; Ana Meireles; Patrícia Pereira; Rui Caceiro; Aléxia Gomes; João Magalhães Pina; Luís Campos Pinheiro
Hospital de São José

Introduction: Perivascular epithelioid cell neoplasm (PEComa) is a rare mesenchymal tumor characterized by distinctive perivascular epithelioid cells, both histologically and immunohistochemically. These tumors can arise in various locations, including the bladder. Bladder PEComa is more frequent in women between the third and fifth decades of life and can present itself asymptomatically, but most patients present with hematuria and persistent lower abdominal discomfort. To date, only 36 case reports of bladder PEComa have been documented in the literature. Human Melanoma Black-45 (HMB-45), a melanocytic marker, is expressed in 100% of bladder PEComa cases, while other markers, including smooth muscle actin, Melan-A, CD117, S100, CD31, and CD34, show variable expression.

Case report: We describe the case of a 75-year-old female patient, who presented with recurrent dysuria, increased urinary frequency, hypogastric pain, and occasional right flank pain over a 4-year period. These episodes were initially attributed to recurrent urinary tract infections, despite negative urine cultures. Renal ultrasound performed twice revealed right ureterohydronephrosis without bladder alterations. In the six months preceding diagnosis, the patient developed hematuria and worsening right flank pain. The CT scan revealed a 10.1x7.8 cm retro- and infravesical pelvic mass involving the bladder and cervix, causing severe chronic right ureterohydronephrosis and significant renal parenchymal thinning. Additionally, a 19x13 mm enlarged left iliac lymph node was noted. The patient underwent a TURB and an irregular bladder lesion covering most of the bladder floor was observed, and an incomplete resection was carried out for diagnostic purposes. Histopathological analysis revealed a malignant neoplasm with pleomorphism, composed of polygonal and rhabdoid cells with marked nuclear atypia. Immunohistochemical staining showed multifocal positivity for MelanA and Desmin, leading to the diagnosis of malignant PEComa. Staging with PET-FDG confirmed a large pelvic mass, left external iliac node involvement, and additional nodules in the left lung and descending colon. The patient underwent anterior pelvic exenteration, including total cystectomy, total hysterectomy, bilateral salpingo-oophorectomy, Bricker's ileal conduit, and Brooke ileostomy. Pathological examination revealed a 14 cm bladder fully occupied by a multinodular tumor with hemorrhagic and necrotic areas infiltrating the bladder wall, uterus, and vagina. Tumor excision margins were close (1 mm). The tumor was characterized as a pleomorphic malignant epithelioid neoplasm with solid architecture, abundant eosinophilic cytoplasm, rhabdoid features, and nuclear atypia. Immunohistochemical markers included positivity for MLANA and MITF, with negative staining for AE1/AER3, CAM 5.2, EMA, SMA, DES, CALDA1, MYOG, MYOD1, S100, CD34, SYP, CHGA, and HMB45. INI1 and SMARCA4 expression were preserved. Lymphovascular and angioinvasion were present, and bilateral pelvic metastases were noted. After multidisciplinary evaluation, the patient started tamoxifen therapy. Postoperative complications included a left-sided ureterohydronephrosis

due to ureteroileal anastomosis stenosis, which required hospitalization and percutaneous nephrostomy. Currently, 20 months post-diagnosis, the patient maintains tamoxifen therapy.

Discussion/Conclusion: This case report describes a rare presentation of PEComa in a 75-year-old female, highlighting several atypical aspects. Unlike all previously reported cases in the literature, this tumor did not express the melanocytic marker HMB-45, a key diagnostic feature in bladder PEComa. Furthermore, the patient's advanced age is unusual for the onset of this disease, which typically presents in younger individuals. These unique features underscore the diagnostic challenges of PEComa and emphasize the importance of considering variant presentations in rare malignancies.

PO 17

INTERVENTIONS TO PROMOTE URINARY CONTINENCE IN PEOPLE UNDERGOING RADICAL PROSTATECTOMY

Ana Patricio Ciuro
Hospital Garcia de Orta

Introduction: Although radical prostatectomy is effective in treating prostate cancer, its complications include urinary incontinence and erectile dysfunction. The high prevalence of these problems negatively affects various aspects of quality of life and can lead to social isolation. Rehabilitation Interventions are essential for them to regain their autonomy in self-control of urinary continence as soon as possible and thus improve their quality of life.

Development: This scoping review aims to map the scientific evidence on interventions to promote urinary continence in this specific context. We developed a methodological framework following the structure proposed by Arksey and O'Malley. We searched for articles in databases such as MEDLINE Complete, CINAHL Complete, MedicLatina, Nursing & Allied Health Collection: Comprehensive, PUBMED and Scopus, in March 2024. Inclusion criteria included articles published in english and portuguese from 2014 to 2024. A total of 276 articles were identified. After analysis and selection, 22 randomised studies were incorporated into this review. Three main categories of interventions to promote urinary continence were identified. Each category has different but interconnected strategies: Educational - with intensive and continuous health education interventions; Behavioural - with cognitive-behavioural and psychological approaches, relaxation techniques, changing habits and voiding training; Functional - based on techniques to strengthen the pelvic floor muscles: Kegel, Pilates, aerobic and strength/hypertrophy exercises, biofeedback, electrostimulation therapy and vibration therapy. Conclusion: Urinary incontinence can affect both physical and mental health. It is crucial to implement a rehabilitation programme to improve quality of life and avoid social isolation . The classification of rehabilitation interventions guides the rehabilitation nurse specialist in choosing the most appropriate strategies, promoting personalised and evidence-based care to achieve excellence in care.

Keywords: prostatectomy, urinary incontinence, interventions, rehabilitation.

PO 18

WHEN ACUTE OBSTRUCTIVE PYELONEPHRITIS DOES NOT SOLVE WITH A JJ STENT – THE IMPORTANCE OF COMPUTED TOMOGRAPHY IN DIAGNOSTICS

Bárbara de Figueiredo[1]; Ana João Guerra[1]; João Lorigo[1]; Vasco Quaresma[1]; Manuel Lopes[1]; Luís Sousa[1]; Arnaldo Figueiredo[1]
[1]Serviço de Urologia, ULS Coimbra

Introduction: Acute obstructive pyelonephritis requires urgent surgical drainage of an obstructed, infected renal pelvis, usually due

to ureteric calculi obstruction. The diagnosis depends on clinical evaluation and imaging, which confirms signs of obstruction, such as hydronephrosis or the obstruction itself.

Objective: To show the importance of computed tomography in diagnostics of an acute obstructive pyelonephritis

Methods: Case Report description

Results: We present a case of a healthy 22-year-old man who presented to the emergency department with right abdominal and lumbar pain, vomiting, and fever that began four days prior after a meal at an Asian restaurant. Laboratory analysis revealed a C-Reactive Protein (CRP) level of 32.91 mg/dL and a leukocytosis of 18.7 x 109/L. Renal function and urinalysis were normal. An abdominal ultrasound revealed right hydronephrosis (images attached) with a urinary calculus measuring 6 mm in the lumbar ureter. Urology was consulted and decided to perform a urinary diversion of the right kidney with a JJ stent and start empirical ceftriaxone. Urine cultures and blood cultures were obtained before starting antibiotics. On the third postoperative day, CRP was 31.8 mg/dL with negative urine and blood cultures. The antibiotic was changed to piperacillin-tazobactam, and a computed tomography (CT) scan was requested. The CT revealed a 13 cm retroperitoneal abscess with some calcified images in its sinus, suggesting possible excretory rupture, although the JJ stent was well positioned and no signs of extravasation of iodinated urine were observed. The CT also showed parietal thickening of the ascending colon adjacent to the abscess (images attached). The abscess was drained, and pus cultures revealed Escherichia coli, Morganella morganii, and Streptococcus constellatus ssp pharyngis. This constellation of microorganisms raised suspicion about the origin of the abscess, and the CT images were reviewed again with general surgeons and radiologists, who agreed that the abscess was probably secondary to a perforated retrocecal appendicitis. After ten days of ureteral stenting, seven days of piperacillin-tazobactam, and abscess drainage, the patient was discharged with a negative CRP and a confirmatory CT of abscess resolution.

Discussion/Conclusions: This case illustrates a supposed obstructive acute pyelonephritis treated with a JJ stent with poor outcome in a 22-year-old male and underscores the importance of computed tomography (CT) in its diagnosis. In this case, neither the history nor the diagnostic exams were strictly compatible with obstructive pyelonephritis, but the ultrasound suggested the diagnosis, leaving little room for other differential diagnoses. Despite being widely available, CT is not always the first imaging modality requested when renal colic is suspected. Ultrasound is often preferred due to its lower cost and lack of radiation exposure. Because ureteral stenting is not without risk and is an invasive procedure, hydronephrosis and ureteral obstruction should be evaluated with CT when planning urinary diversion. This case highlights the importance of CT in the diagnosis of obstructive pyelonephritis.

VD 01

ORTHOTOPIC BILATERAL URETEROCELE MASQUERADING AS A TUMOR IN A WOMAN WITH RECURRENT UTI'S

Bárbara Jacob Oliveira; Pedro Serrano; Gilberto Rosa; Marco Dores; Aníbal Coutinho
Centro Hospitalar Universitário do Algarve - Hospital de Faro

Introduction: Ureteroceles are cystic dilatations of the distal ureter that occur due to congenital ureteric wall weakness. They can be orthotopic, occurring in normal ureteric locations and most commonly seen in adults. On the other hand, heterotopic ureteroceles are located in ectopic ureters or in ectopic duplex renal systems, and are more common in children.
Ureterocele causing obstruction in adults is less commonly reported. Adult Patients present with frequent urinary tract infections, urinary retention and abdominal and pelvic pain.
Goals: To describe the treatment of a 48-year-old female who presented with recurrent urinary tract infections . Subsequent imaging with ultrasound, computed tomography cistoscopy and surgery demonstrated features typical for bilateral ureteroceles.
Methods: Review of patient medical files and previous studies
Results: A 48-year-old female was referred to the urology department from her general practioner for a suspicious of bladder tumor in a CT scan, the patient presented with dysuria, urinary urgency, and frequency. Treatment of four separate culture proven E. coli urinary tract infections with appropriate antibiotics failed to relieve the patient's symptoms. Her past medical history noted recurrent urinary tract infections since childhood.
Complete blood count demonstrated a mildly elevated white blood cell count. The renal function test wasnormal. Initial imaging with ultrasound showed Hydronephrosis of the right kidney and dilated ureters bilaterally projecting into the urinary bladder compatible with bilateral ureterocele at the ureterovesical junction. Review of the previous CT scan: the radiolucent halo surrounding the dense filling area is a filling defect representing the ureterocele wall who can mimic bladder tumors causing hydronephrosis and confuse less experienced radiologists
Subsequently, a cystoscopy was performed and the presence of bilateral ureteroceles was confirmed. A DMSA renal scintigraphy was performed to estimate the functional renal mas and relative renal function.
The patient was taken to the operatting room and endoscopic incision was done as shown in the video
At the second month postoperative the patient noted complete resolution ofsymptoms with no further documented urinary tract infections
Discussion/Conclusions: Single system (orthotopic) ureteroceles are usually discovered in adults and are almost always intravesical. It is bilateral in 10% of cases with female preponderance. Urinary stasis in the dilated distal segment often lends to urinary infection and stone formation; precluding the most common presenting symptoms of dysuria, urgency, and recurrent urinary infections. Intravesical incision of the ureterocele is the treatment of choice in adults and has been described utilizing endoscopic shears and holmium laser technology

VD 02

UNVEILING THE BURIED: A CASE REPORT ON THE SURGICAL MANAGEMENT OF BURIED PENIS

Sara Laranjo Duarte[1]; Felix Campos Juanatey[2]; Paola Calleja Hermosa[2]; Jaime Garcia Herrero[2]; Ana Utiel[2]
[1]ULS Amadora / Sintra; [2]Hospital Universitario Marqués de Valdecilla

Introduction: Buried penis is a complex urological condition that typically involves the entrapment of the penile shaft within surrounding pubic or abdominal tissues. This can impair hygiene, voiding, and sexual function, affecting quality of life?

Adult cases of buried penis are often multifactorial, arising most commonly from obesity, scarring from previous surgeries, penoscrotal lymphedema and/or genital lichen sclerosis. Diabetes and other comorbid conditions that exacerbate skin thickening, adiposity, and fibrosis around the genital area? also contribute to this disease.

Surgical correction is highly individualized, focusing on excess adipose tissue, scarring, and penile shaft fixation to improve both functional and aesthetic outcomes. This correction may be complex and includes techniques such as skin grafting, lipectomy, and pubic lift.

Goals: This case report aims to describe the surgical management of a buried penis from a 66-year-old male with severe voiding impairment. The patient had previous history of abdominoplasty, circumcision and penile reconstruction with grafting. He presents now with a recrudescence of penile burial in fibrotic suprapubic fat. The goal is to highlight the effectiveness of a complex surgery to restore penile exposure, function, and quality of life.

Methods: The patient underwent a suprapubic lipectomy with penile reconstruction with skin graft, under general anesthesia. The procedure was initiated by incising the sclerotic skin to identify the glans and penile shaft. A 14ch Foley catheter was placed, followed by a suprapubic lipectomy with an 800-gram excision of abdominal fat and skin. A pre-existing lymphocele from prior surgery was removed, and bilateral spermatic cords with inguinal hernias were exposed. The hernia defects were repaired with interrupted sutures. Two Blake drains were placed, and the Scarpa's fascia was sutured to the aponeurosis. The subcutaneous plane was closed continuously to prevent dead spaces, and skin was closed with staples. Complete penile shaft mobilization was achieved, and a partial-thickness skin graft, harvested from the resected suprapubic tissue, was applied to the penile shaft with 5/0 Vicryl® sutures.

Results: Postoperative outcomes were favorable, with successful penile shaft exposure and restoration of urinary function. The patient tolerated the procedure without significant complications and expressed satisfaction with the aesthetic and functional results. Follow-up demonstrated stable graft integration and no evidence of recurrence of hernias or lymphocele.

Discussion/Conclusions: This case demonstrates the complexity and success of a tailored surgical approach for buried penis involving extensive lipectomy and careful grafting. Successful outcomes in buried penis cases may benefit of individualized treatment.

VD 03

DISTAL LEFT URETER LESION AFTER LAPAROSCOPIC AND OPEN SURGERIES – STILL A PLACE FOR ROBOTICS?

Rui Caceiro; Hugo Pinheiro; Ana Meireles; Patrícia Pereira; Aléxia Gomes; Pedro Silva; João Amilcar Cunha; Miguel Gil; João Guerra; Luis Campos Pinheiro
Centro Hospitalar de Lisboa Central, EPE / Hospital de Santa Marta

Introduction: Distal Ureteral iatrogenic injuries, though relatively rare, present a challenging complication arising from various

ginecological, urological and general surgeries procedures. Effectively managing such injuries requires a thorough understanding of the available surgical approaches and their associated risks. Several strategies exist for correcting distal ureteral injuries. These include ureteroureterostomy, ureteroneocystostomy with or without psoas-hitch or Boari flap, transureteroureterostomy, and kidney autotransplantation, between others. Each approach can be performed immediately or deferred, using open, laparoscopic, or robotic-assisted techniques. Robotic-assisted procedures offer precision and enhanced visualization, which can be particularly advantageous in complex cases. However, performing robotic surgery after previous operations can present additional challenges, including altered anatomy, scar tissue, and an increased risk of further complications. **Objectives:** To present a clinical case of a 38-year-old female patient that underwent a laparoscopic anterior resection of the rectum and endometriosis foci complicated with distal left iatrogenic ureteral injury managed with left nefrostomy. Post-op complicated by partial rectal anastomotic dehiscence, necessitating open surgery with anastomosis disassembly and a left-sided terminal colostomy. To discuss the various surgical approaches to correct the distal ureteral injury and the challenges faced by the urologist. Additionally, to describe the feasibility, safety, and efficacy of robotic-assisted ureteroneocystostomy with psoas-hitch and lich-gregoir technique.

Methods and Materials: This video was created using both the patient's clinical records and surgery video recordings. Additionally, relevant literature on surgical techniques for correcting ureteral injuries was reviewed. **Results:** The robotic-assisted ureteroneocystostomy with psoas-hitch was successfully completed without intraoperative complications, despite the procedure's difficulty due to extensive peritoneal adhesions. The total operative time was 210 minutes, with minimal blood loss of less than 50 ml. The postoperative course was uneventful, and the patient was discharged on the fifth postoperative day with a bladder catheter.

Discussion/Conclusion: The decision to employ robotic-assisted ureteroneocystostomy with psoas-hitch was influenced by the need to preserve the left- sided terminal colostomy and to avoid compromising conditions for future intestinal reconstruction. Given the challenges of the situation, a second open approach to address the ureteral injury could have severely jeopardized the potential for future intestinal reconstruction. Ureteral and bowel reconstruction during same approach could be too risky, in addition to being extremely difficult too. A robotic-assisted approach aimed to minimize additional trauma and preserve abdominal integrity, which is crucial for any subsequent reconstructive procedures. The success of this procedure, despite the challenging operative conditions, underscores that robotics might still has a space in the managment of complications of previos open and laparoscopic procedures, given its benefits in enhancing surgical precision and visualization. On the other hand, although the outcome was very positive in this case, the benefits and risks should always be weighed before making any surgical decision. A precise, individualized, multidisciplinary decision is essential in such complex cases.

In conclusion, the robotic-assisted approach in this case not only provided a successful outcome but also highlights the potential of robotic techniques in addressing complex ureteral injuries, even after previous complicated open surgeries. This experience supports the continued individualized use of robotic-assisted surgery in the management of challenging ureteral injuries, provided that the specific anatomical and procedural complexities are carefully considered.

VD 04

ABORDAGEM ROBÓTICA NO SÍNDROME DE ZINNER

João Pedro Ferreira Guerra; João Pina; Vanessa Andrade; Miguel Lança; Miguel Gil; Joao Cunha; Rui Caceiro; Luís Campos Pinheiro
Centro Hospitalar de Lisboa Central, EPE / Hospital de Santa Marta

Caso clínico: Homem de 22 anos
Sem história pregressa de relevo
Encaminhado em 2021 a consulta de Urologia por quadro de dor perineal com uns meses de evolução, agravada com ejaculação
Referia ainda polaquiúria e sensação de esvaziamento incompleto
Ao exame objetivo a referir próstata tensa com desconforto ao toque, sem outras alterações.
Ecografia vesical e próstatica revelou estrutura quística junto ao pavimento da bexiga: divertículo vs quisto das vesiculas seminais.
RM: "Rim direito não visualizado por provável agenesia. Dilatação quística da vesícula seminal direita. Concomitantemente verifica-se dilatação do ducto deferente direito. Observa-se conteúdo com hipersinal T1 espontâneo ao nível do ducto deferente direito (até a região do epidídimo) e vesícula seminal (inclui quisto) por provável elevado conteúdo proteico. Próstata normodimensionada (14 cc), com heterogeneidade de sinal periférica sobressaindo área de hipossinal T2 difuso a direita com hiper-realce arterial, sem washout aparente, de provável natureza inflamatória."
Posteriormente foi pedido espermograma com evidência de azoospermia.
Verificado ainda varicocelo à direita
Proposto para excisão da vesicula seminal direita + cura de varicocelo por via robótica
Síndrome de Zinner
Condição rara associada a anomalia embriológica que se desenvolve na porção distal do ducto mesonéfrico entre a 4ª e 13ª semana de gestação
Tríade que inclui agenesia renal unilateral com obstrução do ducto ejaculador e quisto da vesícula seminal ipsilateral
A clínica é variada e inespecífica, incluindo sintomas do trato urinário inferior, hematúria, hematospermia, dor perineal, infeções recorrentes e dor na ejaculação. Em 45% está ainda associada infertilidade
É habitualmente descoberta de forma incidental entre a 2ª e 4ª décadas de vida, período de maior atividade sexual e reprodutiva
Reportados menos de 200 casos na literatura.

VD 05

ROBOTIC-ASSISTED URETHRA-SPARING "MILLIN" PROSTATECTOMY – CHALLENGES OF A MEDIAN LOBE

Miguel Valente Fernandes[1]; Miguel Miranda[1]; Kayhan Hayek[2]; Kris Maes[2]
[1]Centro Hospitalar de Lisboa Norte, EPE / Hospital de Santa Maria; [2]Hospital da Luz Lisboa

Objective: To present a video of a Robotic assisted urethra-sparing "Millin" prostatectomy (RAUSP) in a patient with a prostatic median lobe
Patient and surgical procedure: A 64-year-old diagnosed with benign prostatic hyperplasia, a median lobe protruding 15mm and concerned over ejaculatory preservation underwent RAUSP.
Through a transperitoneal approach, a transcapsular incision is made. The plane between the surgical capsule and the adenoma is identified and dissected until the identification of the urethra.
Minutiose dissection is paramount to avoid any perforation and directly grasping it is to be avoided. If small lacerations are identified, they should be corrected with a 4–0 absorbable monofilament suture.
To facilitate the removal of the large lobes, the anterior commissure is opened.
Removal of the median lobe is done at the end. It's grasped and displaced antero-laterally to achieve the best possible tension and

visibility, ensuring careful mobilization and dissection of the urethra.
Careful hemostasis is advisable, the prostatic capsule is closed with a running two-layer 3/0 barbed suture.
Results: Full urethral preservation was possible. Surgery took 100 min with an estimated blood loss of 150mL. Patient always maintained clear bladder drainage and was discharged on day 2. Bladder catheter was removed on day 4. Patient reports a much-improved quality of life in relation to his urinary symptoms and preserved ejaculatory function.
Conclusions: Although classically described as a technique for patients "without a median lobe", we emphasize it shouldn't be considered an absolute contra-indication to a RAUSP, as it is feasible, safe and effective.

VD 06

TRANSRECTAL ULTRASOUND-GUIDED TRANSPERINEAL PROSTATE BIOPSIES UNDER LOCAL ANESTHESIA

Miguel Lança; João Guerra; João Magalhães Pina; Luís Campos Pinheiro
Hospital de São José

Introduction: Prostate biopsies are a cornerstone in the diagnosis and management of prostate cancer. They are essential for confirming the presence of cancer, determining its grade, and guiding treatment decisions. Traditionally, transrectal ultrasound (TRUS)-guided biopsies have been the standard approach. However, advances in technique have introduced transperineal biopsies as a viable alternative. This approach offers potential advantages, including a lower risk of infectious complications and improved detection rates of clinically significant prostate cancer. Importantly, transrectal ultrasound-guided transperineal prostate biopsies can be performed under either general or local anesthesia, providing flexibility in patient management and comfort. Understanding the nuances of each biopsy technique is crucial for optimizing patient outcomes and ensuring accurate diagnosis.
Goals: To provide a detailed description of the ultrasound-guided transperineal prostate biopsy under local anesthesia, as implemented at a tertiary care center, highlighting the procedural steps, as well as the materials and technology used.
Material and methods: This video provides a detailed description of the various steps involved in performing a ultrasound-guided transperineal prostate biopsy under local anesthesia. The procedure requires several essential materials to ensure accuracy and safety. Local anesthetics, such as lidocaine or bupivacaine, are used to administer a perineal block. A series of needles is needed: 25G and 22G needles for the initial administration of anesthesia, a 17G introducer co-axial needle for access, and a 22G spinal needle for additional anesthetic delivery. For the biopsy itself, a 16-cm 18G biopsy needle with a 2 cm tray is utilized. An ultrasound machine equipped with a biplane transrectal probe, which includes both axial and sagittal transducers, is essential for real-time imaging and guidance. Additionally, sterile drapes and gloves are necessary to maintain a sterile field and minimize the risk of infection.
Results: The patient is positioned in the lithotomy position, with the scrotum taped back and the perineal area disinfected. Local anesthesia is administered to the perineal skin approximately 1 cm anterior and lateral to the anterior anal margin, initially using a 25G needle followed by a 22G needle. A 17G introducer co-axial needle is then inserted at both sites. A transrectal ultrasound (TRUS) probe is introduced and rotated to visualize the lateral part of the prostate gland. A 22G spinal needle is inserted through the co-axial needle to inject local anesthetic into the levator ani muscle complex and the peri-apical

triangle, while carefully avoiding the urethra, penile bulb, and small perineal vessels. This procedure is repeated on the opposite side. Biopsies are then performed using a 16-cm 18G biopsy needle with a 2 cm tray, inserted through the co-axial needle. The angle of the introducer needle may be adjusted during the procedure. Biopsy cores are taken in a cranio-caudal orientation from apex to base, differing from the TRUS biopsy method. Additionally, targeted biopsies are conducted for PIRADS 4 and 5 lesions.

Conclusions: Mastery of the transperineal prostate biopsy technique is crucial given its status as the preferred method for prostate cancer diagnosis according to current scientific evidence. This approach offers significant advantages over traditional methods, including reduced risk of infectious complications and enhanced diagnostic accuracy. Proficiency in this technique ensures reliable detection and management of prostate cancer, ultimately contributing to improved patient outcomes. As the field continues to evolve, maintaining expertise in transperineal biopsy will be essential for optimizing diagnostic precision and advancing clinical practice in urology.

VD 07

HOLMIUM LASER ENUCLEATION OF THE PROSTATE (HOLEP) – DETAILED DESCRIPTION OF THE SURGICAL TECHNIQUE

Miguel Lança
Hospital de São José

Introduction: Holmium Laser Enucleation of the Prostate (HoLEP) has emerged as a highly effective and minimally invasive surgical technique for the treatment of benign prostatic hyperplasia (BPH), particularly in cases involving large prostate volumes. This technique has demonstrated superior outcomes in terms of symptom relief, minimal perioperative complications, and long-term durability when compared to traditional methods such as transurethral resection of the prostate (TURP). Despite its proven efficacy, HoLEP requires advanced surgical skills, making it a procedure best performed in specialized centers.

Goals: To provide a detailed description of the HoLEP surgical technique, as implemented at a tertiary care center, highlighting the procedural steps, as well as the materials and technology used.

Material and methods: This video describes a 69-year-old male with a medical history of BPH and atrial fibrillation, under daily medication with tamsulosin, finasteride, and edoxaban, presented with recurrent episodes of urinary retention. His International Prostate Symptom Score (IPSS) was 22, indicating severe lower urinary tract symptoms. Digital rectal examination revealed no suspicious findings, and his prostate-specific antigen (PSA) level was 4.2 ng/mL. A transrectal ultrasound revealed a prostatic volume of 108 grams. Uroflowmetry findings were consistent with an obstructive pattern. Given the persistence of symptoms and urinary retention despite medical therapy, he was proposed for surgical treatment with Holmium Laser. This approach was selected due to its efficacy in managing large prostates and its safety profile in anticoagulated patients.

Results: Initial cystoscopy is performed to survey the bladder and define the prostate's anatomic configuration, including the verumontanum and ureteral orifices. A hockey stick (J-shaped) incision is made laterally to the verumontanum to identify the adenoma plane, repeated on the contralateral side. Bilateral bladder neck incisions are made at 5 and 7 o'clock positions, extending to the surgical capsule and following the line under the ureteric orifices to the verumontanum. The procedure is again mirrored on the contralateral side. Fibers connecting the median lobe

to the capsule are divided, and the lobe is disconnected at the bladder neck and placed in the bladder for later morcellation. The bladder neck is incised at the 12 o'clock position to release the upper aspects of both lobes, and the incision is extended laterally and distally to the level of the verumontanum, continuing upwards to define the apex. The lower margin of the lobe is released from the apex to the 2 o'clock position, and the apical urethral mucosa is cut to reduce sphincter muscle tension. The entire lobe is enucleated and placed in the bladder for morcellation, with the procedure repeated on the contralateral side. Postoperatively, the prostatic fossa is inspected for hemostasis and vestigial fragments are removed. For morcellation, the inner sheath is replaced with a long nephroscope and adapter, and the bladder set is passed down the instrument channel. After full bladder distension, suction is activated to grasp fragments, and morcellation is performed with care to maintain tissue contact and avoid mucosal injury.

Conclusions: HoLEP proved to be an effective and safe surgical intervention for managing BPH in patients with large prostate volumes. Moreover, this technique is particularly advantageous for patients on anticoagulant therapy due to its reduced risk of bleeding complications. Despite its benefits, HoLEP has a relatively steep learning curve, which underscores the importance of performing the procedure in specialized centers. Mastery of the various surgical steps is crucial for optimizing the technique's efficacy and achieving the best clinical outcomes.

VD 08

LAPAROSCOPIC DISTAL URETERECTOMY AND BOARI FLAP RECONSTRUCTION: DEALING WITH DISTAL URETER CARCINOMA

Margarida André; Luísa Moreira; Marta Vasconcelos; Alexandre Macedo; Nuno Figueira; João Paulo Rosa; Miguel Carvalho
Unidade Local de Saúde Almada Seixal

Introduction: Urothelial carcinoma (UC) is the second most common urological malignancy in developed countries and can be localised in the lower (bladder and urethra) and/or the upper (pyelocaliceal cavities and ureter) urinary tract. Upper tract urothelial carcinomas (UTUC) account for only 5–10% of UCs.

Case presentation: We present the case of a 77-year-old male with a significant smoking history and multiple comorbidities, including chronic kidney disease (CKD). The patient was referred to the urology department with a suspicion of right distal ureteral neoplasia, following diagnostic imaging. A CT scan revealed a suspicious lesion in the pelvic segment of the right ureter, approximately 30 mm from the ureterovesical junction, with evidence of severe hydronephrosis but without extramural extension or lymph node involvement. An MRI confirmed the presence of a 22 mm lesion in the distal ureter, with no apparent invasion of surrounding structures. The patient's therapeutic options were carefully reviewed due to his CKD, with an emphasis on renal preservation. A decision was made to proceed with a minimally invasive distal ureterectomy and ureteral reimplantation using a Boari flap and Psoas-Hitch technique to preserve renal function.

The procedure was performed laparoscopically under general anesthesia, utilizing two 12-mm and two 5-mm infraumbilical trocars. A right distal ureterectomy and peri-meatal cystectomy were completed, followed by ureterovesical anastomosis with Boari flap and

Psoas-Hitch technique. A double-J stent was placed to ensure adequate drainage and healing. A non-aspirative drain was placed.
Drain was removed at third postoperative day. Patient was discharged at 4 days post-op. Bladder catheter was removed at 14 days post-op.
Conclusion: This case underscores the importance of kidney-sparing management for high-risk patients with imperative indications, approached on a case-by-case basis in a shared decision-making process with the patient, despite the higher risk of disease progression, as recommended by EAU guidelines. Distal ureterectomy can be offered to selected patients with high-risk tumors confined to the distal ureter. Our approach allowed for renal preservation through a minimally invasive distal ureterectomy with Boari flap reconstruction, achieving a successful outcome with maintained renal function. Further follow-up is essential to assess long-term outcomes and monitor for disease progression.

VD 09

PELVIC LYMPHADENECTOMY FOR PENILE CANCER: A CASE REPORT AND SURGICAL MANAGEMENT

Margarida André; Luísa Moreira; Marta Vasconcelos; Nuno Figueira; Alexandre Macedo; João Paulo Rosa; Miguel Carvalho
Unidade Local de Saúde Almada Seixal

Introduction: Penile cancer, though rare, often presents with advanced stages at diagnosis, particularly when regional lymph node involvement is detected. In patients with inguinal and pelvic nodal metastasis, lymphadenectomy remains a cornerstone of treatment. Inguinal lymphadenectomy is well-established for controlling locoregional disease, while pelvic lymphadenectomy is a complex procedure typically indicated in patients with positive inguinal nodes or high-risk factors for pelvic spread. This surgical intervention is critical for improving prognosis and ensuring oncological control.
Case Presentation: We present the case of a 72-year-old male with a history of type 2 diabetes, dyslipidemia, and hypertension, who developed an exophytic, erythematous lesion on the penis over the course of one year. The lesion, associated with a small nodule on the prepuce, was diagnosed as invasive squamous cell carcinoma after biopsy. PET-FDG imaging revealed hypermetabolic activity in the penile lesion, along with significant inguinal lymph node uptake, suggesting metastatic involvement. The patient underwent partial penectomy and bilateral inguinal lymphadenectomy, with pathological findings confirming metastasis in three out of nine left inguinal nodes and one out of ten right inguinal nodes, all exhibiting extranodal extension.
Given the metastatic spread to the inguinal lymph nodes and the high risk of further regional disease, laparoscopic pelvic lymphadenectomy was proposed.
The procedure was performed laparoscopically under general anesthesia, utilizing two 12-mm and two 5-mm infraumbilical trocars. Bilateral iliac-obturator lymphadenectomy was performed, involving careful dissection to avoid injury to surrounding structures. A non aspirative drain was placed to prevent the formation of lymphocele. Drain was removed at the third pot-operative day, and the patient was discharged at the fifth day. There were no signs of further complications or recurrence at the follow-up.
Conclusion: Pelvic lymphadenectomy in the context of penile cancer is a crucial procedure in the management of patients with regional lymph node metastasis, particularly when inguinal lymphadenectomy has already been performed, and there is concern for additional pelvic node involvement. This case highlights the importance of timely identification and surgical intervention in preventing further disease progression. The laparoscopic

approach, with its minimally invasive nature, offers advantages in recovery and reduces the risk of long-term morbidity. As penile cancer management evolves, it is critical to offer a personalized, multidisciplinary treatment plan, balancing the risks and benefits of aggressive surgical interventions in high-risk patients. Despite the potential complications, pelvic lymphadenectomy remains a key step in achieving optimal oncological outcomes in advanced penile cancer.

VD 10

MINI-PERCUTANEOUS NEPHROLITHOTOMY ON A RENAL TRANSPLANT GRAFT

Luísa Moreira; Margarida André; Marta Vasconcelos; Alexandre Macedo; Nuno Figueira; João Paulo Rosa; Miguel Carvalho

Hospital Garcia de Orta

Introduction: Kidney stones in transplanted kidneys, though rare, present unique challenges due to the altered anatomy and delicate function of the graft. The presentation is often assyptomatic (found on routine imaging) until complication occur, such as infection, hidronephrosis or acute kidney failure.Mini-percutaneous nephrolithotomy (mini-PCNL) poses as a promising minimally invasive approach for treating stones in renal grafts.

Case Presentation: We report the case of a 64-year-old male with a history of hypertensive nephoscleroris and bilateral nephrectomy for renal tumors (when already under hemodialysis), who received a kidney transplant one year prior to this surgery. He was diagnosed with renal graft lithiasis due to inability to remove doubleJ stent placed at the time of renal transplant. On computed tomography incrustation of the doubleJ stent and moderate hydronephrosis of the graft was found. There was no decline in renal function. An endoscopic approach had previously been attempted without success due to inability to progress to the ureter because of it's insertion on the bladder dome. The patient was scheduled for mini-PCNL. Under ultrasound and fluoroscopic guidance, a direct percutaneous approach to the transplanted kidney was achieved, a 18Ch sheet was placed and lithotripsy with laser holmium:YAG was performed successfully with no intraoperative complications.

No significant changes in renal function were observed post-procedure, and the patient was discharged at day 4 post-op. Follow-up CT was performed at 10 days pos op, and no residual lithiasis was found.

Discussion: Mini-PCNL represents a feasible, safe, and effective option for managing lithiasis in transplanted kidneys. The reduced size of the instruments minimize potential trauma to the transplanted kidney, and the indication for percutaneous approach is the same has for solitary kidneys, with the added advantage of a facilitated access to the renal pelvis comparing with the altered endourologic anatomy. This case underscores the importance of tailored surgical approaches in managing urolithiasis in transplanted kidneys, highlighting the potential of mini-PCNL as a first-line treatment, reinforcing the role of minimally invasive techniques in preserving transplant function and patient quality of life.

VD 11

LAPAROSCOPIC SURGERY IN THE TREATMENT OF URINARY LITHIASIS

Bárbara Jacob Oliveira; Gilberto Pires Rosa; Pedro Serrano; Pedro Barros; Marco Dores; Miguel Cabrita; Aníbal Coutinho

Centro Hospitalar Universitário do Algarve - Hospital de Faro

Introduction: In the modern endourology era, the laparoscopic surgery is still helpful in the management of large or complex urinary stones. Laparoscopy can be indicated after failure of endoscopic techniques or in the presence of malformations that can be treated at the same time.

Goals: We accessed the efficacy of lapa-

roscopy in the treatment of urinary lithiasis presenting last four cases admitted to our urology department.

Methods: We present a short video showing four consecutive cases of laparoscopic treatment in urinary lithiasis, between July and November 2024. Accesses to the kidney and ureter were performed by transperitoneal approach with the placement of three to four ports. The stones were removed directly by pyelotomy or ureterotomy incisions. Concomitant to pyelolithotomy in two patients, additional procedures have included cystolithotomy in one case of forgotten ureteral double j stent and pyeloplasty in another case of ureteropelvic junction obstruction.

Results: In one patient with bilateral lithiasis, left pyelolithotomy was combined with right ureteroscopic lithotripsy. Unexpected adhesions of the right ureter precluded laparoscopic aproach of both sides. All the remaining cases were completed laparoscopically. Stone free status was obtained in all cases. No serious complications ocurred.

Conclusions: In a selected group of patients with complex stone desease, the laparoscopic approach offers good success rates with minimal complications. Stone clearance and correction of malformations could be achieved in a single procedure.

VD 12

LAPAROSCOPIC PARCIAL NEPHRECTOMY - CHALLENGING TUMOR ON A CHALLENGING PATIENT

Luísa Moreira; Margarida André; Marta Vasconcelos; Alexandre Macedo; Nuno Figueira; João Paulo Rosa; Miguel Carvalho
Hospital Garcia de Orta

Introduction: With the widespread use of diagnostic imaging, renal masses are now identified much sooner than in previous decades. Today, between 60% and 70% of renal masses are detected when they are less than 4 cm in diameter and are almost asymptomatic.

The surgical approach to these tumors has also evolved, with a preference for less invasive techniques that preserve oncological safety while enhancing functional outcomes, particularly with regard to renal function. Minimally invasive procedures, such as laparoscopic partial nephrectomy, have gained favor due to their ability to provide excellent oncological results with reduced morbidity. Nephron-sparing surgery (NSS) remains the preferred approach for renal tumors ≤7 cm (T1). Patients with compromised kidney function present with an increased risk for postoperative complications and further deterioration of renal function.

Goals: To present the surgical management of a renal mass in a patient with pre-existing chronic kidney disease (CKD) and highlight the importance of nephron-sparing surgery (partial nephrectomy) in patients with compromised renal function.

Methods: Clinical process and literature review.

Results: We present the case of a 76-year-old male with a history of stage 3 CKD - baseline glomerular filtration rate (GFR) of 38 ml/min/1.73m^2 - of mixed etiology, including hypertension, diabetes mellitus, and a history of nephrolithiasis. He was referred to an urology consult for a solid renal mass identified in an ultrasound requested by his assistant nephrologist. It was latter confirmed with computed tomography (CT), and the patient was diagnosed with an hypodense upper pole renal mass measuring 49 mm in diameter with close contact with the renal sinus (RENAL Score 7p), with no nodal or distant metastasis. The patient was submitted to laparoscopic partial nephrectomy, with Double-J stent placement. The ischemia time was 29 minutes. There were no intra operative nor immediate complications. However, postoperatively, he devel-

oped persistent fever, and a CT scan revealed a residual hematoma adjacent to the resection site. He was treated with intravenous antibiotics, and his condition improved without the need for additional interventions. The patient was discharged on postoperative day 10.

The pathology report revealed a diagnosis of chromophobe renal cell carcinoma (chRCC), pT1bR0.

Discussion/Conclusions: This case highlights the importance of nephron-sparing surgery, especially in patients with compromised renal function. Laparoscopic partial nephrectomy provided effective oncological control while preserving renal tissue, thereby minimizing the risk of further renal decline. The patient's postoperative course was complicated by a residual hematoma, which is a known but typically self-limited complication after partial nephrectomy.

ChRCC, while rare, has a more favorable prognosis than other subtypes of renal cell carcinoma, especially when diagnosed at an early stage. The absence of residual disease (R0) and the pT1bN0M0 staging suggest an excellent long-term prognosis.

Careful surgical planning and perioperative management are essential for minimizing complications and ensuring favorable long-term renal function outcomes. Ongoing surveillance of renal function and imaging is critical to detecting any potential decay in GFR and potencial recurrence.

VD 13

EN-BLOC HOLMIUM LASER TRANSURETHRAL RESECTION OF JUSTAURETERIC BLADDER TUMOR

Manuel Lopes[1], Bárbara Figueiredo[1], Ana Guerra[1], Aline Tregnago[2], Felipe Figueiredo[3]

[1]Serviço de Urologia e Transplantação Renal, Unidade Local de Saúde de Coimbra; [2]Serviço de Anatomia Patológica, Hospital Pompéia, Caxias do Sul, Brasil; [3]Serviço de Urologia, Hospital Pompéia, Caxias do Sul, Brasil

Introduction: Transurethral resection of the bladder (TURB) is the standard technique for histologic diagnosis of bladder tumor, and a staging and treatment procedure in non-muscle-invasive tumors. Traditionally, TURB is performed using bipolar loop for resecting the tumor. En-bloc resection of bladder tumor (ERBT) tries to bridge the gap that traditional resection leaves concerning incomplete resection and cutting the tumor. Laser technology overcomes potential problems of resection using electric energy with good cutting and hemostasis precision.

Goals: To present the case of and ERBT with holmium laser of a lesion close to ureteral orifice.

Methods: Video of and ERBT with holmium laser of a justa-ureteric bladder lesion.

Results: A non-smoker 63 years-old woman with asymptomatic macroscopic hematuria presented with a bladder lesion in abdominal ultrasound. She had no relevant past medical history and no usual medication. Cystoscopy confirmed a single primary polypoid 15mm lesion close to the right ureteral orifice. An ERBT approach using holmium laser was decided.

A 22Fr resectoscope and a Holmium:YAG 550 micron fiber were used, with short pulse for tissue dissection and excision and long pulse for incising the mucosa and hemostasis.

Initial cystoscopy confirms the polypoid lesion close to right ureter orifice.

Procedure starts by marking the limits of the tumor incising the mucosa with a 5mm safe

margin and preserving the ureteral orifice. Progressive dissection is done while hemostasis is controlled, and dissection ensures that muscular layer is excised.

Ureteral meatus was completely preserved. Posterior part of the lesion was then dissected deep enough to excise muscularis mucosa. Complete resection with muscular layer macroscopically present in whole base of the lesion was done. Final hemostasis revision with complete ureter integrity. Surgery took twenty minutes and patient was discharged home in <24h with no bladder catheter. Pathological analysis revealed a non-invasive low grade papillary urothelial carcinoma committed to the mucosa with muscular layer represented in the whole pediculus and lateral margin absent of neoplasia.

Discussion/Conclusions: En bloc resection of bladder tumors is safe. It not only allows more feasible pT1 substaging, but also lateral margins to be evaluated. Tumor size may be challenging but it is not a contraindication for en bloc resection. Using laser for resection avoids the obturator stimulus in lateral wall bladder lesions and so may be safer than traditional resection.

VD 14

MINIMAL INVASIVE LASER ENUCLEATION OF THE PROSTATE: DOWNSIZING THE SCOPE TO AVOID COMPLICATIONS

Manuel Lopes[1], Bárbara Figueiredo[1], Felipe Figueiredo[2]

[1]Serviço de Urologia e Transplantação Renal, Unidade Local de Saúde de Coimbra; [2]Serviço de Urologia, Hospital Pompéia, Caxias do Sul, Brasil

Introduction: Holmium laser enucleation of the prostate (HoLEP) is currently a gold-standard option for the treatment of bladder outlet obstruction (BOO) caused by benign prostatic hyperplasia (BPH) and is gradually replacing transuretral resection of the prostate and open prostatectomy due to its minimal invasive features, eMicacy in adenoma removal and safety profile, providing excellent long term surgical outcomes. It has however a steep learning curve, mainly due to technical aspects.

Goals: To present the case of surgical treatment of BOO performing a HoLEP using a 18.5Ch resectoscope.

Methods: Video of a HoLEP procedure using a 18.5Ch resectoscope.

Results: A 59 years-old man presents with severe voiding and storage lower urinary tract symptoms with years of evolution. He has no history of hematuria nor previous acute urinary retention. He has history of controlled hypertension and dyslipidemia and is currently taking tamsulosin 0.4mg, dutasteride 0.5mg, losartan 50mg and atorvastatin 20mg daily for five years. The prostate ultrasound revealed an enlarged prostate of 110 grams and an unsuspicious bladder, uroflowmetry showed a Qmax of 8mL/s and blood analysis a total PSA of 1.8, with very low PSA-density.

Endoscopic enucleation of the prostate was decided. All HoLEP procedures in the institution are performed by the same surgeon and are executed with a 22Fr resectoscope if prostate is larger than 80 grams or a 18.5Fr resectoscope when prostate is up to 80 grams. A 550 micron fiber of Holmium:YAG laser is used, with short pulse for tissue dissection and long pulse for incising the mucosa and hemostasis.

Initial urethroscopy incidentally found a bulbar urethral stricture impossible to overcome with a 22Fr resectoscope. Downsizing the resectoscope diameter for 18.5Fr instrument it was able to go through the stricture with no urethral trauma.

An en bloc enucleation was performed with early apical release and preserving the sphincteric mucosa. Then, progressive liberation of prostatic lobes from the apex to the base of the prostate and from medial to lateral was done until bladder neck is achieved on the

left and then repeating the same steps on the right lobe. Adenoma is completely released to the bladder and surgery is complete after adenoma morcellation. Enucleation time was of 1 hour 40 minutes and morcellation time of 15 minutes. Procedure had a total time of 2 hours 20 minutes. Patient was discharged home in the first 24 hours with no bladder catheter and no peri-operative complications. Pathological analysis revealed chronic prostatitis and BPH.

Discussion/Conclusions: HoLEP is a size independent procedure for BPH surgical treatment. Small caliber instruments intended to avoid urethral trauma and minimized stricture chance and sphincteric preservation attempts to achieve early continence. Dorsal flap during apical liberation is another factor that helps achieving immediate continence.

Smaller resectoscopes have the drawback of lower saline flow, that may be a concern regarding endoscopic vison during enucleation, and working close to the enucleation plane, what makes it easier to lose the correct plane and possibly perforate the capsule. So experience plays a key role in executing the technique.

VD 16

RETROPERITONEAL LAPAROSCOPIC PARTIAL NEPHRECTOMY

Bárbara de Figueiredo[1], Andreia Santos[2], João Lorigo[1], Manuel Lopes1, Luís Sousa[1], Arnaldo Figueiredo[1]

[1]Serviço de Urologia, ULS Coimbra; [2]Serviço de Cirurgia Geral, Centro Hospitalar Tondela-Viseu, EPE

Introduction: This video represents a case of a posterior renal cell cancer in a 69-year-old male with a history of multiple previous surgeries and a single functional kidney. Due to the location of the renal mass and the patient's medical history, we chose a retroperitoneoscopic approach to the kidney.

Objectives: To show a different approach of posterior renal masses.

Methods: The patient is placed in the standard flank position, with the kidney bridge elevated, and the operating table flexed to maximize the space between the lowermost rib and the iliac crest. The retroperitoneum space is developed using a spherical balloon dissector. Care must be taken not to dissect too anteriorly to avoid opening the peritoneum. Full inflation of the balloon dissector requires approximately 500 cc of air. The balloon system is then deflated, and the retroperitoneal space is inspected for adequacy of dissection, hemorrhage, and anatomical landmarks. The last two ports are placed under vision. The psoas muscle acts as a landmark. After opening the Gerota fascia posteriorly, the great vessels are noted medially, The renal artery is identified as a pulsating, vertically oriented structure. The renal hilum is dissected, and the renal vein and renal artery are cleared of fat. The posterior kidney face is inspected in order to identify the lesion. After clear isolation of the mass, a bulldog clamp is used to clamp the artery. Resection of the lesion is done with arterial clamping and ensuring a negative surgical margin. The resection bed is sutured with a barbed suture v-lock and using SURGICEL™ Absorbable Hemostat. The artery is declamped after 10 minutes and the resection bed inspected for hemostasis and the specimen is extracted with a laparoscopic endobag.

Results: Blood loss was 100 ml and the patient was discharged on the second postoperative day. The histology revealed a pT1a chromophobe renal cell cancer with negative margins.

Discussion/Conclusions: The retroperitoneoscopic approach has proven to be an effective technique for the resection of posterior renal tumors, offering a minimally invasive alternative with rapid postoperative recovery. This technique should be considered in similar cases to reduce morbidity associated with peritoneal manipulation.

ORGANIZATION

UNIDADE LOCAL DE SAÚDE ALMADA - SEIXAL

HOSPITAL Garcia de Orta E.P.E.

ORGANIZING COMMITTEE

President Miguel Carvalho

Alexandre Macedo
João Paulo Rosa
Luísa Moreira
Margarida André
Marta Vasconcelos
Nuno Figueira

SCIENTIFIC COMMITTEE

Afonso Gonçalves
Ana Isabel Santos
Aníbal Coutinho
Arnaldo Figueiredo
Avelino Fraga
David Subirá
Estevão Lima
Fernando Ferrito
Hélder Mansinho
José Palma dos Reis
Luís Campos Pinheiro
Miguel Ramos

SCIENTIFIC ENDORSEMENT

Patrocínio Científico – Ordem dos Médicos

APCIR Associação Portuguesa de Cirurgia Robótica

Associação Portuguesa de Urologia

Sociedade Portuguesa de Cirurgia

Sociedade Portuguesa de Oncologia

SPONSORS

astellas	BAYER	Bristol Myers Squibb	Boston Scientific – Advancing science for life
Coloplast	EXCELENCIA ROBÓTICA	inmunotek	IPSEN – Innovation for patient care
Johnson&Johnson Innovative Medicine	RECORDATI	life well pharmaceutical	MoonSurge – We feel surgery
AstraZeneca / MSD	NOVARTIS | Reimagining Medicine	OLYMPUS	SPCare – Especialidades Farmacêuticas Lda.
tecnimede	teprel – we health you		

SECRETARIAT

admédic+ CONGRESS, MEETING & EVENT MANAGEMENT

Calçada de Arroios, 16 C, Sala 3 1000-027 Lisboa
+351 21 842 97 10 (chamada para a rede fixa nacional)
elsa.sousa@admedic.pt | www.admedic.pt