

# ABSTRACTS OF THE 20th ANNUAL MEETING OF THE ITALIAN SOCIETY OF URO-ONCOLOGY (SIUrO)

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Faculty of Medicine "A. Gemelli"  
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learning curve for minimally invasive nephron-sparing surgery (NSS). Different minimally invasive approaches have been recently developed. Microwave (MW) ablation requires neither ischaemia, tumour excision, nor renal reconstruction, thus making the technique more simple and the learning curve shorter.

*Patients and Methods:* An 81-year-old male presented at our Hospital asking for therapy for a single upper polar renal tumour found during a CT-scan required for anaemia. Surgery, open or robotic seemed to us too invasive with regard to the patient's age, the size of the tumour, and the comorbidities (diabetes, former stroke, hypertension, high serum-creatinina and anaemia). We chose a transperitoneal access. A 3-arm Da Vinci System with a bedside assistant was used for the procedure. Three trocars (two 8-mm robotic trocars and one 12-mm trocar for the optic) were placed in a triangulated configuration; and one additional 10 mm assistant port was placed at 6-7 cm medially with respect to the lower robotic trocar. The colon was mobilized, incising the peritoneum from the spleen attachments to the iliacal vessels and parallel to the descending colon, allowing identification of the upper renal pole. Intraoperative US allowed the precise identification of the tumour site and Gerota's fat layer covering the tumour was then removed. A needle biopsy was performed and frozen section assessed, showing a renal cell carcinoma. A 17-G MW probe was then inserted into the tumour until its tip reached the deepest margin of the lesion under US control. Thermoablation using a 35-W microwaves generator (HS Amica Apparatus for Microwave ablation®, HS SpA, Rome, Italy) was performed. Periodic US allowed control such that thermoablation front entirely covered the lesion. MW time was 5 min. No bleeding occurred at needle extraction. Overall operative time was 90 min.

*Results:* The patient was dismissed on day 2, with stable haemoglobin and serum creatinine levels. The level of pain (colour scale) was 1. Non analgesic therapy was given. CT scan performed after 1 month and US scan performed after 6 months showed complete destruction of the tumour and no relapse.

*Conclusion:* In our initial experience, robotic-assisted microwave ablation seems to be a safe and effective treatment for small renal tumours in patients with high surgical risk or who refuse surgery.

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**INGUINOSCROTAL HERNIA CONTAINING**  
**OCCULT BLADDER CANCER: CASE REPORT**

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*Background:* We report an unusual case of invasive urothelial bladder cancer arising within the herniated dome of the bladder in a inguinoscrotal hernia.

*Case Report:* An 80-year-old man was referred to our Department complaining of 3 months persistent macroscopic haematuria and LUTS. An abdominal contrast-enhanced CT scan, performed 1 month earlier, had ruled out renal masses or stones and had showed herniation of the bladder dome into a left inguinoscrotal hernia. The bladder was described as being free of any luminal mass, although dysmorphic, with thickening of the herniated bladder wall. Physical examination was unremarkable, except for pallor and the evidence of a non reducible left-sided inguinoscrotal swelling. The prostate was slightly enlarged and fibrous on palpation. Laboratory investigations revealed severe chronic anaemia (Hb 8 g/dl) and the patient underwent blood transfusion. Flexible and rigid cystoscopies were carried out, but we were not able to inspect the herniated bladder dome due to a very narrow and tight isthmus, which did not allow the progression even of the 16 Fr. flexible scope. Urine cytology for malignant cells was negative. We then decided to perform an inguinal hernioplasty, dissecting the bladder dome free from the hernial sac and a TURP. During the operation, the herniated bladder was extremely hard on palpation and it was consequently resected and sent for frozen sections, which revealed a high-grade transitional cell carcinoma. A partial cystectomy was finally performed and the definitive histology showed a 3.5 cm ulcerated hard mass, consistent of undifferentiated transitional cell carcinoma, infiltrating the bladder wall, with negative margins and foci of carcinoma *in situ* in the remaining mucosa. Hernioplasty with polypropylene mesh and TURP were completed uneventfully. The patient was discharged on the 5th postoperative day in good condition and is now undergoing adjuvant chemotherapy. Approximately 1-3% of inguinal hernias in adults are associated with herniation of the bladder, which is seldom identified preoperatively and it is an exceptional site for neoplasm (1), with fewer than 15 cases reported in the literature since 1943 (2). In patients with urinary symptoms and bladder hernias, accurate diagnostic investigations that allow the evaluation of the herniated bladder wall are of paramount importance and mandatory to exclude the presence of neoplasm.

*References*

- 1 Escudero J, Ulises J *et al*: Inguinoscrotal bladder hernias. Arch Esp Urol 60(3): 231-236, 2007.
- 2 Oppenheimer GD: Incarcerated inguinal hernia containing a cancer of the bladder. J Urol 50: 784-785, 1943.

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**INTRAOPERATIVE RADIOTHERAPY FOR**  
**LOCALLY ADVANCED PROSTATE CANCER: A**  
**MATCHED PAIR ANALYSIS**