대한비뇨기종양학회

KUOS 뉴스레터

The Korean Urological Oncology Society

Vol. No 2015_1

CONTENTS

회장 인사말

친애하는 대한비뇨기종양학회 회원 여러분!

순하고 사회적이면서 화목의 상징인 을미년, 양의 해를 맞이하여 비뇨기종양학회 회원님과 가정에 건강과 행복이 함께하시길 진심으로 기원합니다.
아울러 지난 한해 학회 발전을 위한 회원 여러분들의 열정과 성원에 감사를 드립니다.

올해부터 우리 학회의 발전과 젊은 동료 회원들이 미래에 종양 관련 국제학회에서 주도적인 역할을 할 수 있는 발판을 마련하기 위해 희망하는 기관에 단기간 해외연수를 지원하고자 합니다. 젊은 회원 여러분들의 적극적인 참여를 바랍니다.
대한비뇨기종양학술지는 대한전립선학회와 공동으로 발행하고 있습니다. 한국연구재단에 우리 학술지의 등재(후보) 추진을 위해서는 회원 여러분의 적극적인 참여와 투고가 필요하오니 많은 관심을 부탁드립니다.
비뇨기종양학회 회원의 소통과 화합을 위해 원로회원과 젊은회원을 모시고 금년 6월 경에 워크숍을 실시하고자 하오니 회원 여러분의 적극적인 참여를 기대합니다.

우리 비뇨기종양학회가 더욱 발전할 수 있도록 2015년에도 회원 모두의 아낌없는 협조와 성원을 부탁드립니다.
희망 가득한 을미년, 뜻하신 일 모두 이루시길 바라며
새해 복 많이 받으십시오.

2015년 1월
대한비뇨기종양학회 회장 김 형 진 큰절

대한비뇨기종양학회
서울특별시 강남구 일원로 81 (일원동, 삼성서울병원암병원6층 비뇨기과교수연구실)

2014년 3차 집담회 및 송년회

[대한비뇨기종양학회 집담회 및 송년회 안내]

대한비뇨기종양학회 회원 여러분 안녕하십니까?
다사다난했던 2014년이 어느덧 아득한 추억 속으로 빠져들고 있습니다. 한 해를 뒤돌아보고 보다 성숙한 새해를 맞이하기 위한 학술 집담회 겸 송년 모임에 참여하셔서 뜻 깊은 자리를 만들어 주시기를 부탁 드립니다. 아울러 동절기에 건강 유의하시고 댁내 여유로움이 함께 하기를 진심으로 기원합니다.

* 학술집담회 이전 **4시 30분**에 **상임이사회**를 함께 가질 예정입니다. 상임이사분들께서는 참석을 부탁 드립니다

일정안내

- **상임이사회** 12월 9일(화) 오후 4시 30분
  제일약품 본사 12층 대회의실 (서울시 서초구 반포동745-5 번지)
- **집담회** 12월 9일(화) 오후 6시
  제일약품 본사 12층 대강당 (서울시 서초구 반포동745-5 번지)
- **송년회** 12월 9일(화) 오후 7시 이후
  꽃담, 교보타워점 (서울시 서초구 반포동 1302-40 번지 (교보타워 뒷편), 02-3482-5277)

[2014년도 3차 비뇨기종양학회 학술집담회 프로그램]

17:50-18:00	개회사 및 인사말	대한비뇨기종양학회 김형진 회장
18:00-18:20	**특강** A pending issue of hereditary renal cell carcinoma	**좌장: 김형진 (전북의대)** 한준현 (한림의대)
18:20-19:00	**증례토의** Hereditary RCC 증례 Panels: 홍성준(연세의대), 안한종 (울산의대), 한준현 (한림의대), 송채린 (울산의대),	**좌장: 조진선 (한림의대)** 진행: 정병창 (성균관의대)

대한비뇨기종양학회 회장 김 형 진


2014
3차 집담회
개회사 및 인사말
17:50-18:00

제 5회 공동심포지움

2015년 제 5회 대한ENDOUROLOGY학회 대한비뇨기종양학회 공동심포지움

· 일시 : 2015년 1월 24일(토) 14:00-17:50 · 장소 : 부산 해운대백병원
· 평점 : 대한의사협회 2점

초대의 글

대한비뇨기과학회 회원 여러분 안녕하십니까?
2015년도 을미년 청양의 해가 밝았습니다. 올 한해 늘 건강하시고 바라는 소망 모두 이루시길 기원합니다.

오는 1월 24일(토) 부산 해운대백병원에서 개최되는 제5회 대한ENDOUROLOGY학회-대한비뇨기종양학회 공동심포지움에 회원 여러분을 초대하고자 합니다. 양 학회는 유수한 역사와 전통 속에서 각자의 분야에서 비뇨기과학의 발전에 공헌 해 왔습니다. 최근 복강경 및 로봇 수술로 대표되는 최소침습수술의 발전으로 이러한 술기들이 비뇨기 종양 환자들에게 널리 적용되면서 양 학회는 공통의 관심사에 대해 공동연구의 필요성을 절감하게 되었습니다. 이에 양 학회는 2013년부터 네 번의 공동심포지움을 성황리에 개최한 바 있습니다.

이번 제5회 심포지움에서는 양 학회에서 활발하게 활동하고 계시는 선생님들을 모셔서 전립선암과 신장암에 대한 로봇 및 복강경 수술 등의 최신 술기에 관한 강의를 준비하였고 또한, 이와 관련된 흥미있고 유익한 case를 통해 활발한 토의를 진행할까 합니다.

진료와 연구에 바쁘시겠지만, 부디 참석하셔서 제 5회 대한ENDOUROLOGY학회-대한비뇨기종양학회 공동심포지움을 축하해 주시고 열띤 토론의 장을 열어주시기 바랍니다.

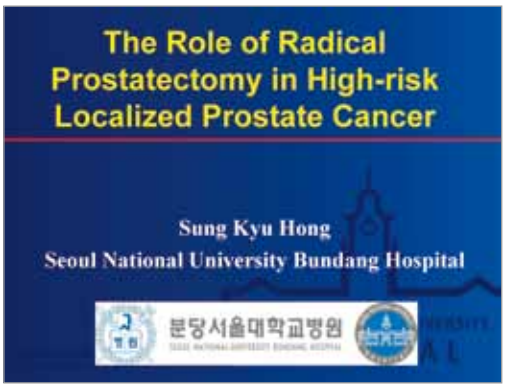
감사합니다.

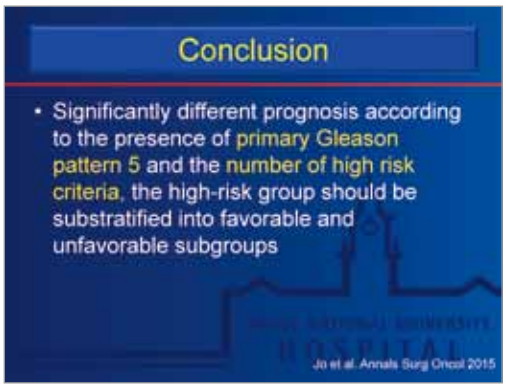
대한ENDOUROLOGY학회장 **권 태 균**
대한비뇨기종양학회장 **김 형 진**

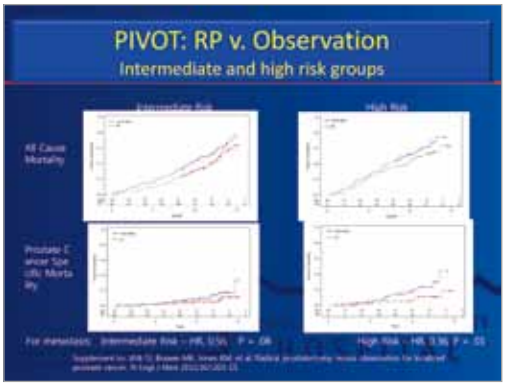
프로그램

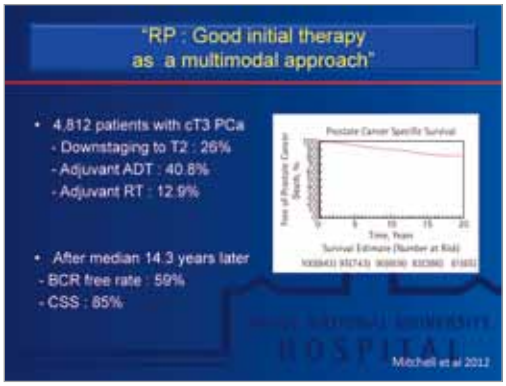
14:00-14:30	Registration	
14:30-14:40	Welcome Address	권태균 (대한ENDOUROLOGY학회 회장) 김형진 (대한비뇨기종양학회 회장)
14:40-16:00	**Symposium I: Radical Prostatectomy**	좌장: 권태균 (경북의대), 안한종 (울산의대)
	The Role of Radical Prostatectomy in High-risk Localized Prostate Cancer	홍성규 (서울의대)
	New Surgical Technique of Robot-Assisted Radical Prostatectomy	나군호 (연세의대)
	Case Discussion: 나군호 (연세의대), 홍성규 (서울의대), 박성우 (부산의대), 권동득 (전남의대)	
16:00-16:20	Coffee break	
16:20-17:40	**Symposium II: Partial Nephrectomy for T1b or T2 Renal Tumor**	좌장: 서일영 (원광의대), 정진수 (국립암센터)
	Is Partial Nephrectomy Safe for T1b or T2 Renal Tumor?	송채린 (울산의대)
	Minimally Invasive Partial Nephrectomy Technique for T1b or T2 Renal Tumor	전승현 (경희의대)
	Case Discussion: 전승현 (경희의대), 송채린 (울산의대), 이승배 (서울의대), 서성일 (성균관의대)	
17:40-17:50	Closing	

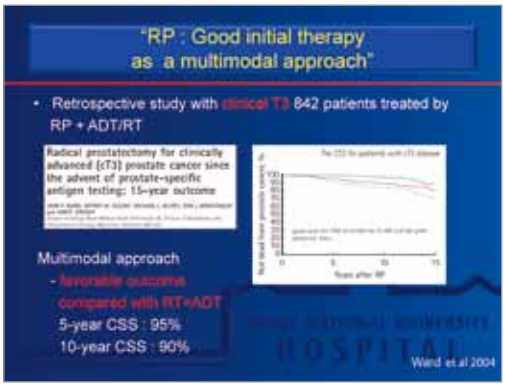
홍성규

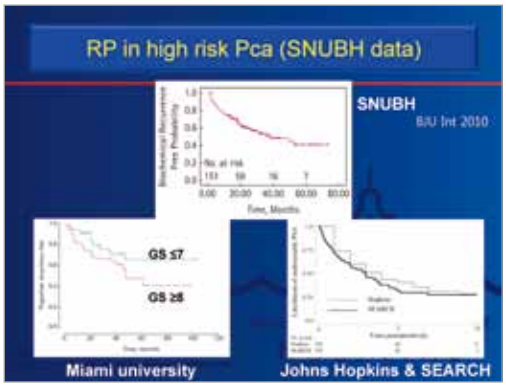

The Role of Radical Prostatectomy in High-risk Localized Prostate Cancer
Sung Kyu Hong
Seoul National University Bundang Hospital
분당서울대학교병원

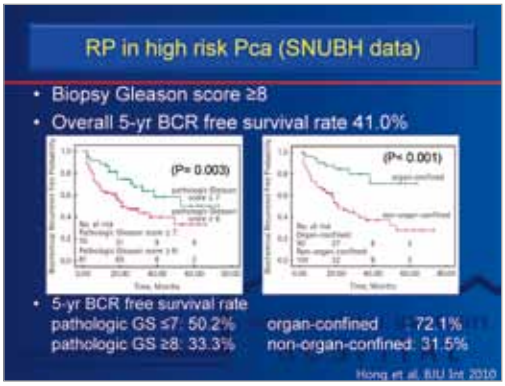

Conclusion
• Significantly different prognosis according to the presence of primary Gleason pattern 5 and the number of high risk criteria, the high-risk group should be substratified into favorable and unfavorable subgroups
Jo et al. Annals Surg Oncol 2015

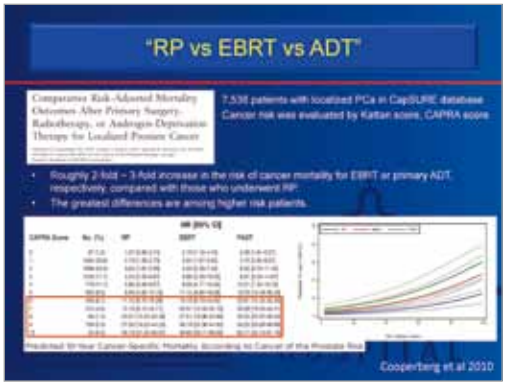

PIVOT: RP v. Observation
Intermediate and high risk groups

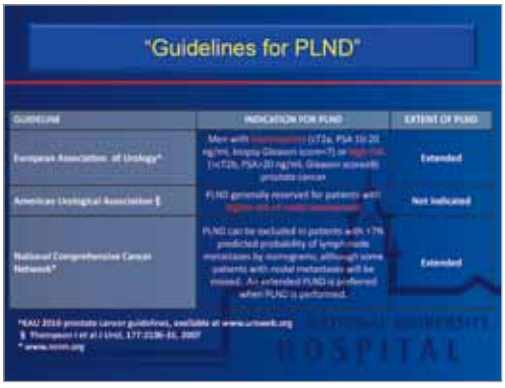

"RP : Good initial therapy as a multimodal approach"
• 4,812 patients with cT3 PCa
- Downstaging to T2 : 26%
- Adjuvant ADT : 40.8%
- Adjuvant RT : 12.9%
• After median 14.3 years later
- BCR free rate : 59%
- CSS : 85%
Mitchell et al 2012

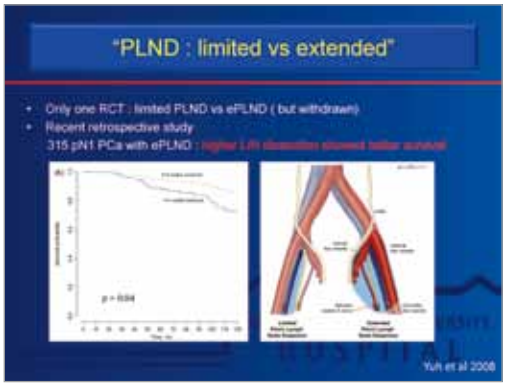

"RP : Good initial therapy as a multimodal approach"
• Retrospective study with clinical T3 842 patients treated by RP + ADT/RT
Radical prostatectomy for clinically advanced (cT3) prostate cancer since the advent of prostate-specific antigen testing: 15-year outcome
Multimodal approach
- favorable outcome compared with RT+ADT
5-year CSS : 95%
10-year CSS : 90%
Wind et al 2004

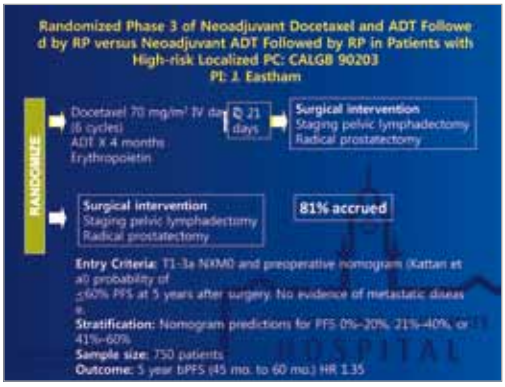

RP in high risk Pca (SNUBH data)
SNUBH
BJU Int 2010
GS ≤7
GS ≥8
Miami university
Johns Hopkins & SEARCH

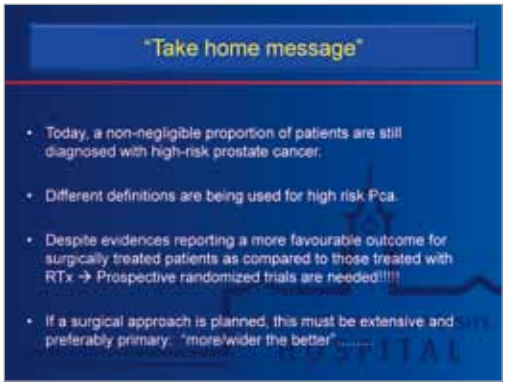

RP in high risk Pca (SNUBH data)
• Biopsy Gleason score ≥8
• Overall 5-yr BCR free survival rate 41.0%
(P= 0.003)
(P< 0.001)
• 5-yr BCR free survival rate
pathologic GS ≤7: 50.2%
pathologic GS ≥8: 33.3%
organ-confined : 72.1%
non-organ-confined: 31.5%
Hong et al. BJU Int 2010


"RP vs EBRT vs ADT"
7,538 patients with localized PCa in CaPSURE database
Cancer risk was evaluated by Kattan score, CAPRA score
• Roughly 2-fold – 3-fold increase in the risk of cancer mortality for EBRT or primary ADT, respectively, compared with those who underwent RP
• The greatest differences are among higher risk patients
Cooperberg et al 2010

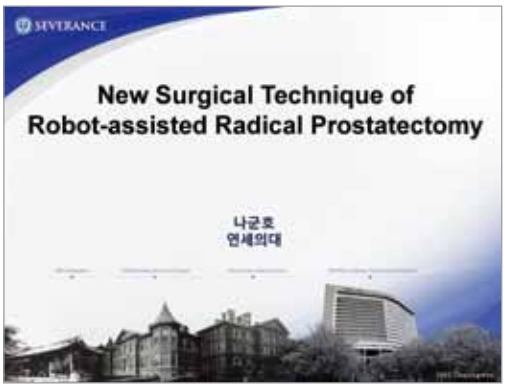

"Guidelines for PLND"
INDICATION FOR PLND
EXTENT OF PLND
Extended
Not indicated
Extended

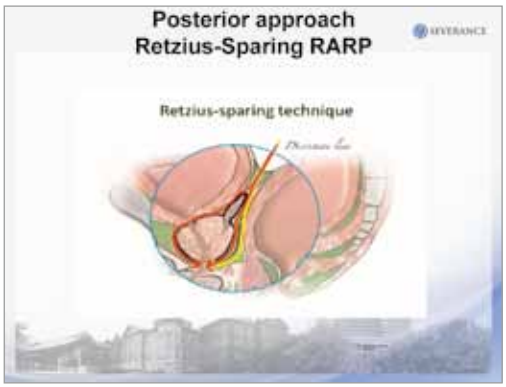

"PLND : limited vs extended"
• Only one RCT : limited PLND vs ePLND (but withdrawn)
• Recent retrospective study
315 pN1 PCa with ePLND :
p = 0.04
Yuh et al 2008


Randomized Phase 3 of Neoadjuvant Docetaxel and ADT Followe d by RP versus Neoadjuvant ADT Followed by RP in Patients with High-risk Localized PC: CALGB 90203
PI: J. Eastham
RANDOMIZE
Docetaxel 70 mg/m² IV day 1 (6 cycles)
ADT X 4 months
Erythropoietin
≤ 21 days
Surgical intervention
Staging pelvic lymphadectomy
Radical prostatectomy
Surgical intervention
Staging pelvic lymphadectomy
Radical prostatectomy
81% accrued
Entry Criteria: T1-3a NXM0 and preoperative nomogram (Kattan et al) probability of ≤60% PFS at 5 years after surgery. No evidence of metastatic disease.
Stratification: Nomogram predictions for PFS 0%–20%, 21%–40%, or 41%–60%
Sample size: 750 patients
Outcome: 5 year bPFS (45 mo. to 60 mo.) HR 1.35


"Take home message"
• Today, a non-negligible proportion of patients are still diagnosed with high-risk prostate cancer.
• Different definitions are being used for high risk Pca.
• Despite evidences reporting a more favourable outcome for surgically treated patients as compared to those treated with RTx → Prospective randomized trials are needed!!!!!
• If a surgical approach is planned, this must be extensive and preferably primary: "more/wider the better"

나군호


SEVERANCE
New Surgical Technique of
Robot-assisted Radical Prostatectomy
나군호
연세의대


Posterior approach
Retzius-Sparing RARP
SEVERANCE
Retzius-sparing technique


Posterior approach
Retzius-Sparing RARP
SEVERANCE
Surgical Techniques
1. Mobilisation of the colon and posterior peritoneal incision
2. Athermal dissection of seminal vesicles
3. Posterior dissection
4. Lateral dissection and nerve-sparing
5. Bladder neck dissection
6. Vesico-urethral anastomosis
7. Packing and closure of peritoneal incision
8. Pelvic lymph node dissection


Retzius-sparing robot-assisted laparoscopic radical prostatectomy: combining the best of retropubic and perineal approaches

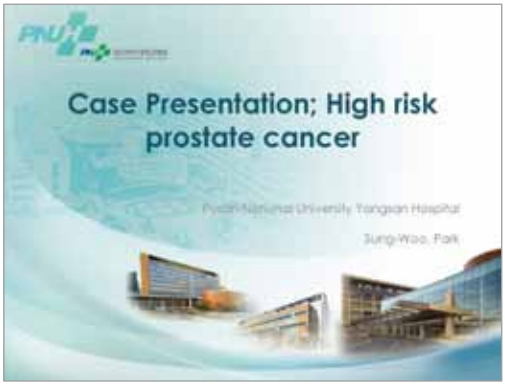

eau
Beyond the Learning Curve of the Retzius-sparing Approach for Robot-assisted Laparoscopic Radical Prostatectomy: Oncologic and Functional Results of the First 200 Patients with ≥1 Year of Follow-up

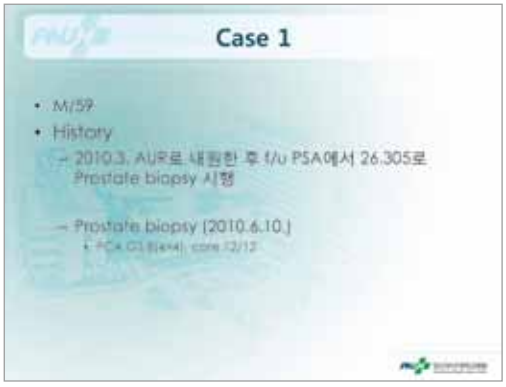

Posterior approach
Retzius-Sparing RARP
SEVERANCE
Yonsei Experience
Setting
Single surgeon data
1137 anterior RARP cases from 2005 to 2012
250 posterior RS-RARP cases form 2012 to 2014
Propensity-matched analysis
anterior-RARP (250 patients of recent 500 cases)
versus posterior RS-RARP (250 patients)
1:1 Matched 250 cases using pre-operative
characteristics
(Age, BMI, PSA, Gleason score, Clinical T stage

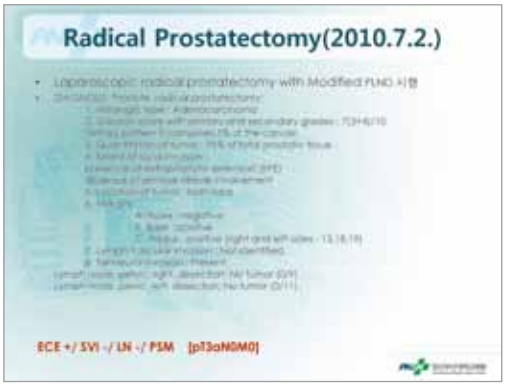

Posterior approach
Retzius-Sparing RARP
SEVERANCE
• Overall complication rate, 4%(ant.) vs 3.6%(post.), p=0.722
• 1-year biochemical recurrence free survival rate, 85.9%(ant.) vs 83.2%(post.), p=0.11
• Overall positive surgial margin rate,
• 29.6%,(ant.) vs 25.2% (post.) p=0.084
• Continence rate of posterior RS-RARP on 1,6,12 months, 82% 92%, 96%


Retzius-Sparing RARP
: Yonsei experience
SEVERANCE
Posterior RS-RARP has higher continence rate and comparable oncologic safety.
Long term and randomized controlled studies needed to verify this novel technique

박성우


Case Presentation; High risk prostate cancer
Pusan National University Yangsan Hospital
Sung-Woo, Park


Case 1
• M/59
• History
→ 2010.3. AUR로 내원한 후 f/u PSA에서 26.305로 Prostate biopsy 시행
→ Prostate biopsy (2010.6.10.)


Radical Prostatectomy(2010.7.2.)
ECE +/ SVI -/ LN -/ PSM [pT3aN0M0]


The changes of PSA
Early salvage Radiation
7.22
0.751

Case 2

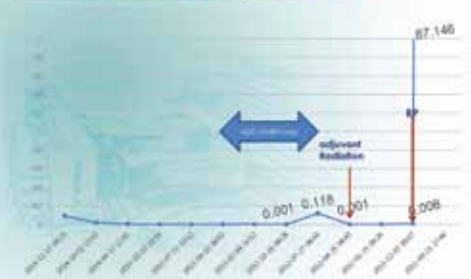
- M/69
- History
  - 배뇨장애 증상으로 local 비뇨기과의원 내원하여 PSA 검사상 81 로 본원 의뢰됨.
  - PSA 87.146 (2011.9.21)
  - Prostate biopsy
    - PCA GS 9(4+5) core 7/10

Radical prostatectomy (2011.10.27.)

- Laparoscopic radical prostatectomy with modified PLND

ECE +/ SVI +/ LN -/ PSM [pT3bN0M0]

The changes of PSA



Case 3

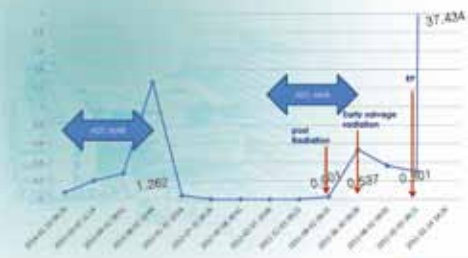
- M/70
- History
  - 2011.3. Slip down으로 head confusion 으로 타병원 입원 중 검사한 PSA 21.57로 Prostate biopsy 시행.
  - Prostate biopsy
    - PCA GS 9(3+6) core 6/12, both lobe

Radical Prostatectomy(2011.4.4.)

- Laparoscopic radical prostatectomy with modified PNLD
- Pathology: Prostate, radical prostatectomy
  1. Histologic type : Adenocarcinoma
  2. Gleason score with primary and secondary grades : 9(5+4)/10
  3. Quantitation of tumor : 40% of total prostatic tissue
  4. Extent of local invasion :
  5. Capsular penetration-pathologic extension (EPE)
     Seminal vesicle invasion (SVI) : Seminal vesicle and vas deferens involvement
  6. Location of tumor : both lobes
  7. Margins :
     A. Apex : negative
     B. Base : positive
     C. Bladder : positive
  8. Lymph/vascular invasion : Present
  9. Perineural invasion : Present
  Lymph node, pelvic, right, dissection : Adenocarcinoma, metastatic (1/7)
  Lymph node, pelvic, left, dissection : Adenocarcinoma, metastatic (1/8)

ECE -/ SVI +/ LN +/ PSM [pT3bN1M0]

The changes of PSA



Case 4

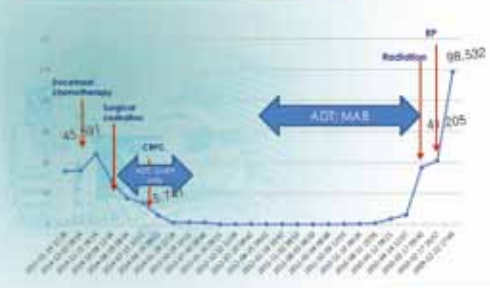
- M/55
- History
  - 2009년 12월 금약뇨, 배뇨통 증상으로 개인의원에서 검사상 PSA 83.57로 본원 비뇨기과 내원
    본원 PSA 98.532
  - Prostate biopsy (2009.12.30) 시행
    → PCA GS 8(4+4), core 6/12, Lt. only

Radical Prostatectomy (2010.1.19.)

- Laparoscopic radical prostatectomy with Modified pelvic lymph node dissection
- Pathology report:
  Adenocarcinoma, Gleason grade 8 (4+4)/10, with
  1) multifocal involvement of bilateral lobes
  tumor volume - 90% of total prostate volume
  2) extraprostatic extension
  3) presence of multiple perineural invasions
  4) suspicious foci of lymphovascular tumor emboli
  5) involvement of radial resection margins
  6) involvement of left seminal vesicles and no involvement of right seminal vesicle and bilateral vasa deferentia.
  Prostate, bilateral margin, right, biopsy: No tumor.
  Lymph nodes, pelvic, [left and right], dissection (x2):
  Adenocarcinoma, metastatic [left: 1/8 and right: 1/9].

ECE +/ SVI +/ LN +/ PSM [pT3bN1M0]

The changes of PSA

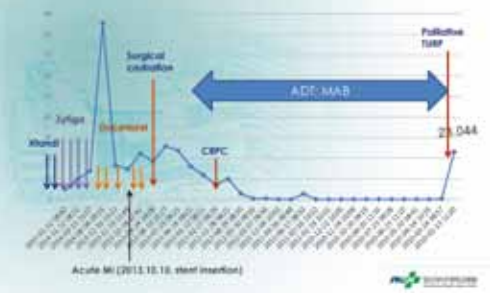


Case 5

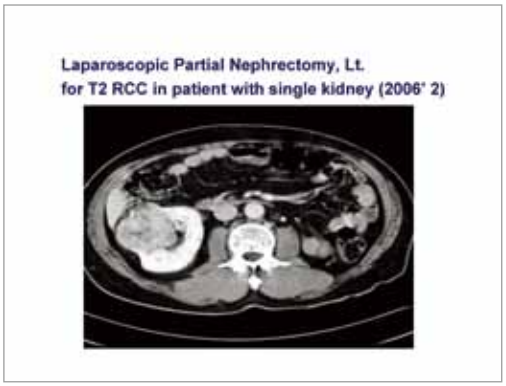
- M/58
- History
  - PSA (2009.12.7.) 13.51로 Prostate biopsy (2010.1.5.) 시행하고 PCA 진단 받고 내원. AUR 경험도 있으며, 내원 당시에도 심한 배뇨장애 증상 있었음
  - GS 8(4+4), core 3/10, Lt. side only
  - TRUS: Prostate volume 45gm
  - DRE +, Lt. palpable nodule+

Clinical stage T2b, high risk

The changes of PSA



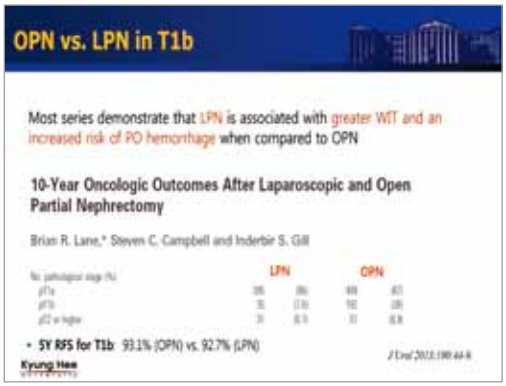
서일영

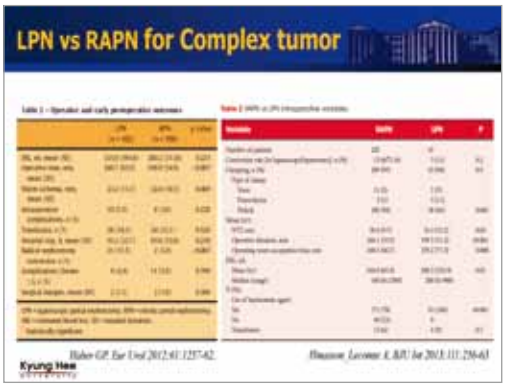

Laparoscopic Partial Nephrectomy, Lt.
for T2 RCC in patient with single kidney (2006' 2)

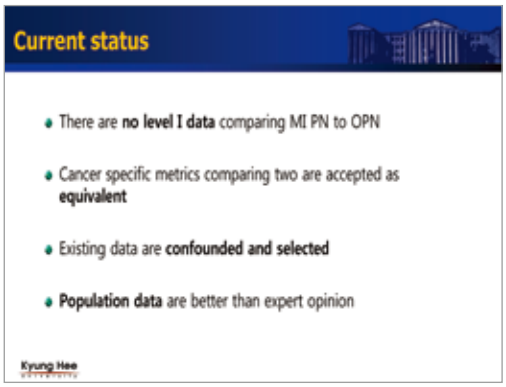

3D Imaging Solution
OLYMPUS

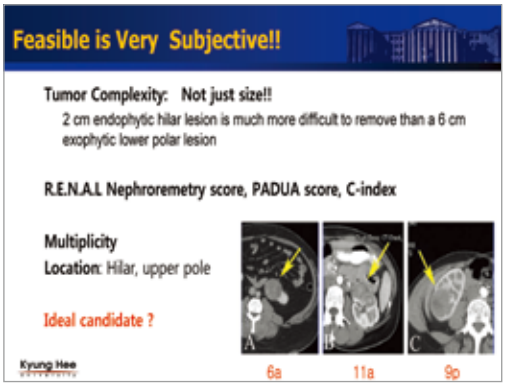
전승현

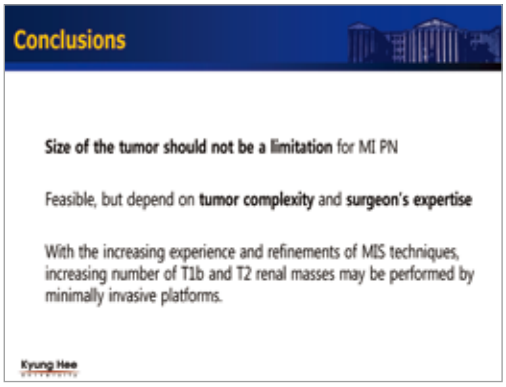

Minimally Invasive Partial Nephrectomy for T1b or T2 Renal Tumor
Seung Hyun Jeon
Kyung Hee University


OPN vs. LPN in T1b
Most series demonstrate that LPN is associated with greater WIT and an increased risk of PO hemorrhage when compared to OPN
10-Year Oncologic Outcomes After Laparoscopic and Open Partial Nephrectomy
Brian R. Lane,* Steven C. Campbell and Inderbir S. Gill
LPN
OPN
5Y RFS for T1b: 93.1% (OPN) vs. 92.7% (LPN)
Kyung Hee

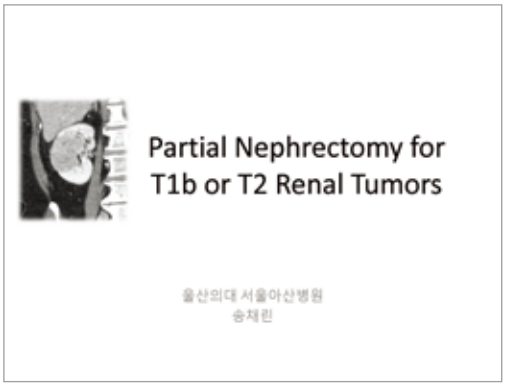

LPN vs RAPN for Complex tumor
Kyung Hee

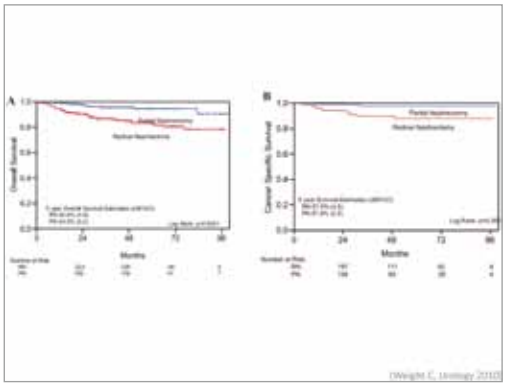

Current status
There are no level I data comparing MI PN to OPN
Cancer specific metrics comparing two are accepted as equivalent
Existing data are confounded and selected
Population data are better than expert opinion
Kyung Hee

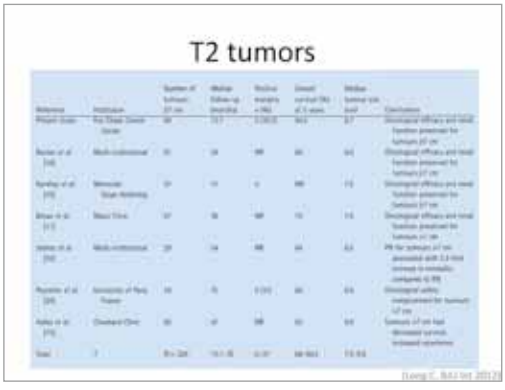

Feasible is Very Subjective!!
Tumor Complexity: Not just size!!
2 cm endophytic hilar lesion is much more difficult to remove than a 6 cm exophytic lower polar lesion
R.E.N.A.L Nephroremetry score, PADUA score, C-index
Multiplicity
Location: Hilar, upper pole
Ideal candidate ?
Kyung Hee
6a
11a
9p

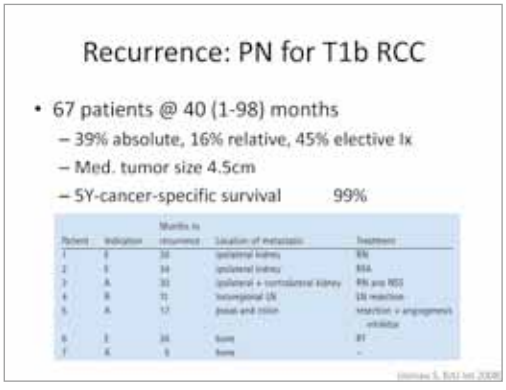

Conclusions
Size of the tumor should not be a limitation for MI PN
Feasible, but depend on tumor complexity and surgeon's expertise
With the increasing experience and refinements of MIS techniques, increasing number of T1b and T2 renal masses may be performed by minimally invasive platforms.
Kyung Hee

송채린


Partial Nephrectomy for T1b or T2 Renal Tumors
울산의대 서울아산병원
송채린




T2 tumors


Recurrence: PN for T1b RCC
• 67 patients @ 40 (1-98) months
– 39% absolute, 16% relative, 45% elective Ix
– Med. tumor size 4.5cm
– 5Y-cancer-specific survival 99%

Recurrence: PN for T2 RCC

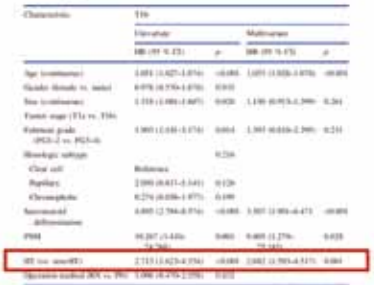
- 69 patients @ 3.2 years
  - Med. Tumor size 7.5 cm
  - Recurrence

	PN	RN
Distant	22%	33%
Isolated local	6%	3%

→ PN increases risk of isolated local recurrence (unadjusted HR 2.11, 95% CI 0.62-7.22)

(Breau R, J Urol 2009)

Prognostic factors for RFS



(Shim M, Annal Surg Oncol 2015)

Presurgical TKI for T1b Tumors

(Ged N, Curr Opin Urol, 2013)

Take Home Message

- Although technical applicability appears to have become unquestionable, partial nephrectomy for T1b/2 RCC patients can be considered in *select* patients including those with absolute (and imperative) need to save renal function.
- For a wider (or general) application, maturation of oncological outcome data, demonstration of definitive survival benefit or identification of eligible subgroup of patients will be mandatory.

이승배

LPN for T2 RCC

서울특별시보라매병원 비뇨기과

이승배

M/47

- Incidentally found right renal mass
- Informed of renal mass 4years ago
- PMHx> DM/HT: denied, HIVD L4-5
- Labs>

  Hb 16.1
  Cr 0.89, eGFR 92.0
  Ht 176cm, Wt 98.4Kg, BMI 31.8Kg/m^2

What do you think the best treatment for this patient?

1. Open radical nephrectomy
2. Laparoscopic radical nephrectomy
3. Open partial nephrectomy
4. Laparoscopic partial nephrectomy
5. Others

2014-04-18 LPN for RKLP 9.5cm mass

- Transperitoneal approach
- 4 trocars
  1. Rt RLB, U-2, 12mm, for laparoscope
  2. Rt RLB, U+7, 12mm, for right hand
  3. Rt AAL, U-2, 5mm, for left hand
  4. Sub-xyphoid, 5mm for liver traction

LPN for RKLP 9.5cm mass

- 20 minutes after clamping artery and vein
- Complete resection of the tumor
- But,
  1. Renal capsule is pulled up to about 1cm from the parenchymal resection margin.
  2. Moreover, the remaining parenchyma looks like very tiny.
  3. And, the lower pole major calyx or renal pelvis is wide open.
  4. Huge renal vein is wide open to the longitudinal axis and is bleeding in torrents

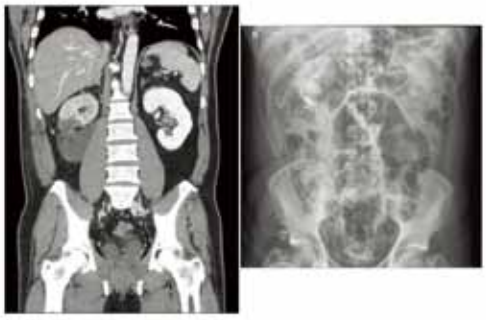
LPN for RKLP 9.5cm mass

- 20-40 minutes after clamping artery
  - More parenchymal resection
  - Complete calyx suture with 3-0 Vicryl
- Additional 5 minutes
  - to repair the resection bed with 3-0 V-Loc suture

LPN for RKLP 9.5cm mass

- Finally 55 minutes after clamping artery
  - complete renorrhaphy with 1-0 Vicryl sutures, interrupted x4
- After renorrhaphy
  - a quaterly-cut-surgicel
  - Tissel 2ml.
  - covering the renorrhaphy wound with one more surgicel

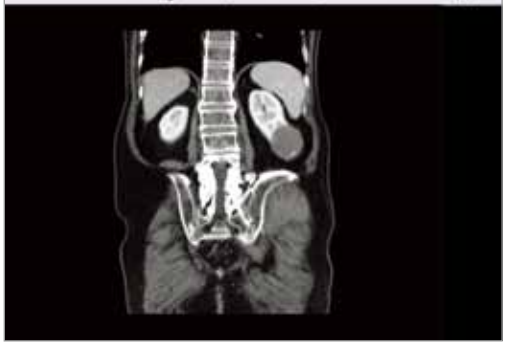
Postop. 1week



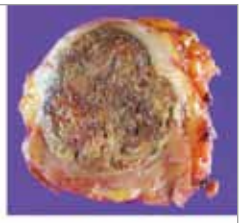
서성일

- M/69
- **Chief complaint** : incidentally Lt. detected renal mass found in regular check up
  (onset: 1 month ago)
- **Medical history / Operation history**: (-/-)
- **Social history** : smoking (25 pack year)
- BMI: 27.88
- **Lab** : CBC, electrolyte = normal
  BUN/Cr = 14.8/0.9 mg/dl
  Urine microscopy = RBC 11-20/HPF

Initial kidney CT (size : 6cm, R.E.N.A.L score 9p)



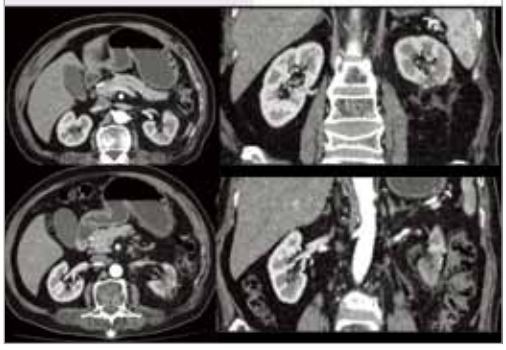
Treatment



- 2013-09-24
- Laparoscopic-partial nephrectomy was done
  (trans-peritoneal approach)
- Warm Ischemic time :
  → 25mins 42secs
- EBL : 250cc

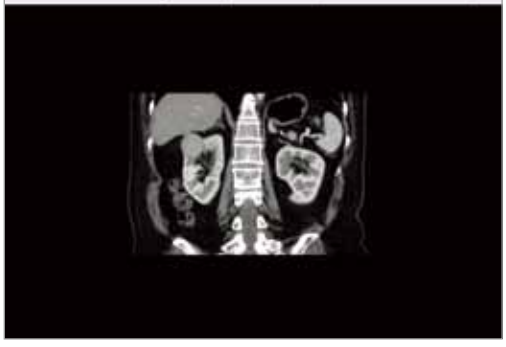
Pathology : Renal cell carcinoma, **papillary type**.
Fuhrman's nuclear grade III/IV:
1) tumor size: **5.7x5.0 cm**
2) **involvement of renal capsule with penetration (T3)**
3) negative resection margin (safety resection margin: 0.8 cm)

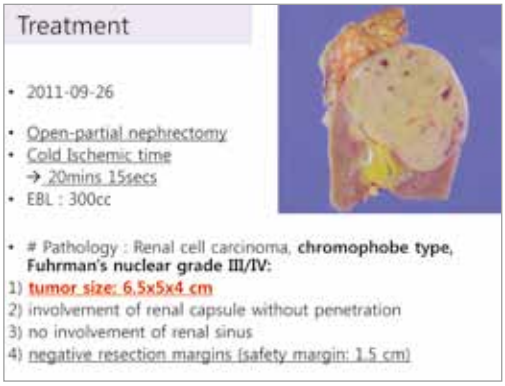
Kidney CT (POD 3months)

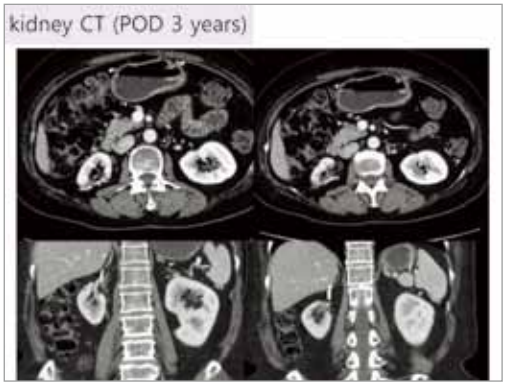


- F/59
- **Chief complaint** : microscopic hematuria
  (onset: 1 weeks ago)
- **Medical history / Operation history**: (DM/-)
- **Social history** : (-)
- BMI: 24.76
- **Lab** : CBC, electrolyte = normal
  BUN/Cr = 9.2/0.63 mg/dl
  Urine microscopy = RBC 3-5/HPF

Initial kidney CT (size : 6.8cm, R.E.N.A.L score 8x)




Treatment
• 2011-09-26
• Open-partial nephrectomy
• Cold Ischemic time
→ 20mins 15secs
• EBL : 300cc
• # Pathology : Renal cell carcinoma, chromophobe type, Fuhrman's nuclear grade III/IV:
1) tumor size: 6.5x5x4 cm
2) involvement of renal capsule without penetration
3) no involvement of renal sinus
4) negative resection margins (safety margin: 1.5 cm)


kidney CT (POD 3 years)


2015년 제5회
대한ENDOUROLOGY학회·대한비뇨기종양학회 공동심포지움

공지사항

2015년 행사일정

- 2015년 3월 27일 금요일 - 대한비뇨기종양학회 EAUOG symposium - 서울아산병원
- 2015년 3월 28일 토요일 - 대한비뇨기종양학회 Multidisciplinary Conference - 서울아산병원
- 2015년 6월 6일 -7일 토, 일요일 - 대한비뇨기종양학회 워크샵
- 2015년 8월 29일 토요일 - 대한비뇨기종양학회 학술대회 -차의대 바이오컴플렉스
- 2015년 10월 24일 토요일 - 대한비뇨기종양학회-대한내비뇨기과학회 공동 심포지엄
- 2015년 12월 8일 화요일 - 집담회 겸 송년회

The 13th KUOS Multidisciplinary Conference 잠정프로그램

- 일시: 2015년 3월 28일 (토)
- 장소: 서울아산병원 6층 대강당

08:30-09:00	Registration	
09:00-09:05	President's Welcome	대한비뇨기종양학회장 김형진
09:05-09:10	Congratulatory Remarks	대한비뇨기과학회장 주명수
09:10-10:10	Symposium (I): Current issues in diagnosis and prognosis of MIBC 1. Diffusion-weighted MR imaging for preoperative staging 2. Prognosis of histologic variants for bladder urothelial carcinoma 3. Systemic inflammatory responses (SIR) as prognostic factors 4. LN-dependent variables as prognosis markers	
10:10-10:30	Memorial lecture	좌장: 김형진 (전북의대) 안한종 (울산의대)
10:30-10:50	Coffee break	
10:50-12:10	Consensus meeting (I): Treatment of MIBC 1. Neoadjuvant chemotherapy: new standard of care 2. Adjuvant chemotherapy 3. Trimodality bladder-sparing approach Panel discussion	

12:10-13:30	Luncheon symposium The sequential use of abiraterone and enzalutamide in castrate resistant prostate cancer patients: abiraterone acetate or enzalutamide first? David Crawford (University of Colorado)
13:30-14:30	Symposium (II): Updates of prostate cancer 1. Prostate imaging-reporting and data system (PIRADS) 2. Handling of RP specimen: emphasis on the evaluation of margin status 3. Role of surgery for advanced prostate cancer 4. Current status of intermittent androgen deprivation
14:30-15:10	Invited Lecture Androgen annihilation as a new therapeutic paradigm in advanced prostate cancer David Crawford (University of Colorado)
15:10-15:30	Coffee break
15:30-16:50	Consensus meeting (II): Low-risk prostate cancer 1. Comparison of active surveillance protocols 2. Novel biomarkers in the era of active surveillance 3. Various treatment options for low-risk prostate cancer
16:50-17:30	총회

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류프로렐린아세트산염 3.75mg / 11.25mg

* Source: Synovate, 2011 Aug ** Source: Takeda internal data. 2011

루프린 - 주 3.75mg ..... **보험고시가** 148,415원 / Vial

효능·효과 : 중추성사춘기조발증, 자궁내막증, 자궁근종, 전립선암, 폐경전 유방암 **용법·용량 :** 1. 자궁내막증: 보통 성인에는 4주 1회 류프로렐린아세트산염으로서 3.75mg 을 피하주사 한다. 단, 체중이 50kg 미만의 환자에게는 1.88mg을 투여한다. 또한 초회투여는 월경주기 1~5일째에 한다. 2. 자궁근종: 보통 성인에는 4주 1회 류프로렐린아세트산염으로서 1.88mg 을 피하주사 한다. 단 체중과다 환자, 자궁종대가 고도인 환자에는 3.75 mg을 투여한다. 또한 초회투여는 월경주기 1~5일째에 한다. 3.전립선암,폐경전 유방암: 보통 성인에는 4주 1회 류프로렐린아세트산염으로서 3.75mg 을 피하주사 한다. 4. 중추성 사춘기조발증 : 보통 4주 1회 류프로렐린아세트산염으로서 체중 kg 당 30㎍을 피하주사한다. 또한 증상에 따라 체중 kg 당 90㎍까지 증량할 수 있다. **Needle Gauge :** 25G **현탁용액 :** 1mL **첨부용제 :** Gelatin Free

루프린 DPS 3.75 mg ..... **보험고시가** 148,415원 / Syringe

효능·효과 : 자궁내막증, 자궁근종, 전립선암, 폐경전 유방암 **용법·용량 :** 1. 자궁내막증: 보통 성인에는 4주 1회 류프로렐린아세트산염으로서 3.75mg 을 피하주사 한다, 또한 초회투여는 월경주기 1~5일째에 한다. 2. 자궁근종: 보통 체중과다 환자, 자궁종대가 고도인 환자에는 4주 1회 류프로렐린아세트산염으로서 3.75 mg 피하주사한다. 또한 초회 투여는 월경주기 1~5일째에 한다. 3. 전립선암, 폐경전 유방암 : 보통 성인에는 4주 1회 류프로렐린아세트산염으로서 3.75mg 을 피하주사 한다. **Needle Gauge :** 25G **현탁용액 :** 1mL **첨부용제 :** Gelatin Free

루프린 DPS 11.25mg ..... **보험고시가** 233,332원 / Syringe

효능·효과 : 자궁내막증, 자궁근종, 전립선암, 폐경전 유방암 **용법·용량 :** 1. 자궁내막증: 보통 성인에는 12주 1회 류프로렐린아세트산염으로서 11.25mg 을 피하주사 한다. 또한 초회투여는 월경주기 1~5일째에 한다. 2.진행성 전립선암, 폐경전 유방암: 보통 성인에는 12주 1회 류프로렐린아세트산염으로서 11.25 mg 을 피하주사 한다. 3. 자궁근종: 보통 체중과다 환자, 자궁종 대가 고도인 환자에는 12주 1회 류프로렐린아세트산염으로서 11.25 mg 피하주사한다. 또한 초회 투여는 월경주기 1~5일째에 한다. **Needle Gauge :**23G **현탁용액 :** 1mL **첨부용제 :** Gelatin Free

사용상의 주의사항: 얼굴의 화끈거림, 열감, 어지럼증, 어깨결림, 두통, 불면, 식욕부진, 오심, 구토, 우울상태 등 ※처방 시 제품 설명서를 참조하세요.

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