



KUOS 뉴스레터

The Korean Urological Oncology Society

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Q 비뇨기종양학회 - 새해인사



謹賀新年

친애하는 대한비뇨기종양학회 회원
여러분!



희망찬 새해가 밝았습니다. 새해를
맞이하여 비뇨기종양학회 회원님과
가정에 건강과 행복이 함께하시길 진심으로
기원합니다.

아울러 지난 한해 학회 발전을 위한 회원 여러
분들의 열정과 성원에 감사를 드립니다. 지난해 우리 비뇨기종양학회
가 여러 분야에서 좋은 결실을 맺을 수 있었던 것은 회원 여러분들의
학회에 대한 사랑과 열정이 있었기에 가능했다고 생각합니다.

새해에도 회원 여러분과 함께 우리 학회의 여러 사업을 차질없이 진행
하고 학회 발전을 위해 더욱 정진할 것을 다짐합니다.

우리 모두가 함께하면 무엇이든지 할 수 있습니다. 비뇨기종양학회가
더욱 발전할 수 있도록 2016년에도 회원 모두의 아낌없는 협조와 성
원을 부탁드립니다.

희망 가득한 丙申年, 뜻하신 일 모두 이루시길 바라며,
새해 복 많이 받으십시오.

2016년 1월
대한비뇨기종양학회 회장 김 형 진 큰절

Q 제28회 대한비뇨기종양학회 정기학술대회



2015년 제 6회 대한비뇨기종양학회·대한ENDOUROLOGY학회 공동 심포지엄

| 일시 | 2015년 10월 24일 (토) 14:00-17:50

| 장소 | 수원 아주대학교병원

| 평점 | 대한의사협회 2점



초대의 글

대한비뇨기과학회 회원 여러분 안녕하십니까?

2015년 10월 24일 개최되는 제6회 대한비뇨기종양학회-대한 ENDOUROLOGY학회 공동 심포지엄에 회원 여러분을 초대하게 되어 기쁘게 생각합니다. 대한비뇨기종양학회와 대한ENDOUROLOGY학회는 우수한 역사와 전통 속에서 각자의 분야에서 대한비뇨기과학회의 발전에 공헌을 해왔습니다. 최근 복강경 및 로봇 수술로 대표되는 최소침습수술의 발전으로 비뇨기종양 환자들에게 최소침습수술이 널리 적용되면서 양 학회의 공통 관심사에 대한 여러 차원에서의 의견 교류와 공동 연구의 필요성을 보다 절감하게 되었습니다. 이에 2013년부터 양 학회 공동심포지엄을 개최하게 되었으며 그 동안 5회의 공동 심포지엄에서 많은 회원 여러분들의 참석과 활발한 의견 교류가 이루어졌습니다.

아주의대에서 개최하게 되는 이번 공동 심포지엄에서는 고령의 방광암 환자에서의 치료 및 신경/전립선보존 근치적방광절제술의 술식과 고위험 전립선암 환자에서의 신경보존술 및 로봇보조 근치적 전립선절제술의 최신 지견에 대해 토의하게 되었습니다. 관련 분야에서 활발히 연구를 하시고 임상 경험을 축적하신 선생님들을 좌장 및 연자로 모시고 해당 분야 이슈를 정리할 수 있는 유익한 시간이 되실 것으로 생각합니다. 각 강의에 이어 임상에서의 고민을 심도 있게 논의하고 서로의 경험을 공유할 수 있는 흥미로운 증례 토의도 준비하였으니 활발한 토의가 되었으면 합니다.

이번 공동 심포지엄이 회원들간에 유익한 정보를 나누며, 비뇨기과의 학문적 발전을 도모할 수 있는 장이 되기를 기원하며 회원 여러분들의 적극적인 참여와 토의 부탁드립니다.

감사합니다.

대한비뇨기종양학회 회장 김 형 진
 대한ENDOUROLOGY학회 회장 권 태 군

PROGRAM

14:00-14:30 Registration

14:30-14:40 Welcome Address

김형진 (대한비뇨기종양학회 회장)
 권태군 (대한ENDOUROLOGY학회 회장)

14:40-16:00 Symposium I: Radical Cystectomy and Urinary Diversion

좌장 김형진 (전북의대), 성경탁 (동아의대)

1. Challenges in the Management of Invasive and Advanced Bladder Cancer in Elderly Patients: Solutions? 구자현 (서울의대)
2. Nerve-sparing/Prostate-sparing Radical Cystectomy: Indications and Surgical Technique 강석호 (고려의대)

Panel Discussion : 구자현 (증례, 서울의대), 서호경 (국립암센터), 정병창 (성균관의대),
 홍범식 (증례, 울산의대), 강석호 (고려의대), 정승일 (전남의대)

16:00-16:20 Coffee break

16:20-17:40 Symposium II: Prostate Cancer

좌장: 안한중 (울산의대), 나군호 (연세의대)

1. Nerve Sparing for High Risk Prostate Cancer Patient. Is It Needed? And How? 박홍석 (고려의대)
2. Progression in surgical anatomy and technique after introduction of RARP 박진성 (울지의대)

Panel Discussion : 홍성후 (증례, 가톨릭의대), 권동득 (전남의대), 박홍석 (고려의대),
 정창욱 (증례, 서울의대), 전승현 (경희의대), 박진성 (울지의대)

17:40-17:50 Closing

사전등록

1. 등록비는 무료입니다.
2. 사전등록 방법 : 아래 내용 기재하셔서 이메일로 접수 부탁드립니다.
 - 기재사항 : 성명 / 소속(병원명) / 의사면허번호 / 이메일주소 / 연락처
 - 접수 및 문의처 : 준비사무국 02) 704-8574, app@app2010.com
3. 사전등록 기간 : 10월 21일(수) 까지



구자현

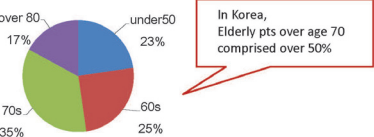
Challenges in the management of
invasive and advanced bladder
cancer in elderly patients: Solutions?

Ja Hyeon Ku, M.D., PhD

Associate Professor of Urology
Department of Urology,
Seoul National University School of Medicine

Korean Data

- 3,485 new patients in 2012 (1.6% of total cancer)
- 6.9 cases per 100,000 population
- Male: female = 4:1.1
- Age distribution



National Cancer Information Center (<http://www.cancer.go.kr>)

Key points

- A comprehensive geriatric assessment
- **Radical cystectomy** has a survival benefit even in elderly pts & should be considered in eligible pts.
- **Neoadjuvant chemotherapy** is well tolerated and effective in selected elderly pts with MIBC.
- **Adjuvant chemotherapy** should be considered in high-risk (lymph node positive or extravesical tumor extension) pts.
- **Trimodality therapy** is a well tolerated, effective, and potentially curative alternative to radical cystectomy in selected pts with MIBC.

Benefit of radical cystectomy

- Several studies have demonstrated that even MIBC pts over age 80 have a **survival benefit after radical cystectomy**.
- A SEER analysis showed that there is an OS benefit for elderly pts undergoing radical cystectomy with PLND, but that benefit becomes **negligible without PNLD**.
- Radical cystectomy may also help **reduce local symptoms** such as pain and hematuria.

Hollenbeck et al, Urology 2004, Chammie K et al, BJU int 2008, Farnham SB et al, Urol Oncol 2014

Choice of procedure
for radical cystectomy

- Elderly pts undergo continent urinary diversion with neobladder **less often than younger pts**.
- They have slower resumption of continence after surgery and higher rates of stress incontinence, but the **majority of elderly pts** do achieve continence with a neobladder.
- The overall complication rate, survival, and quality of life **do not appear to differ** between procedures.
- Pts should have a PNLD **regardless of age**.
- Ability to care for a urinary diversion or perform **intermittent catheterization** should also be considered prior to surgery.

Horowitz D et al, BJU int 2012, Liberman D et al, Urology 2011, Sogni F et al, Urology 2008

Trimodality therapy (TMT)

- TMT has emerged as an alternative combining a complete TUR-BT as safely possible, XRT, and concurrent chemotherapy.
- TMT can be used in selected candidates for cystectomy with certain tumor characteristics who **prefer bladder preservation or in those who are not candidates for cystectomy**.
- In a recent review of TMT, the median complete response rate based on eight studies was 72% with **comparable** median 5-year cancer-specific survival rates to radical cystectomy (52%).
- Long-term outcomes of several pooled Radiation Therapy Oncology Group (RTOG) studies showed favorable 5-year OS with TMT (57%) and pts age 75 or greater had **no difference in outcomes** compared with younger pts.

Gray PJ et al, Eur Urol 2013, Turgeon GA et al, Front Oncol 2014, Mak RH et al, J Clin Oncol 2014

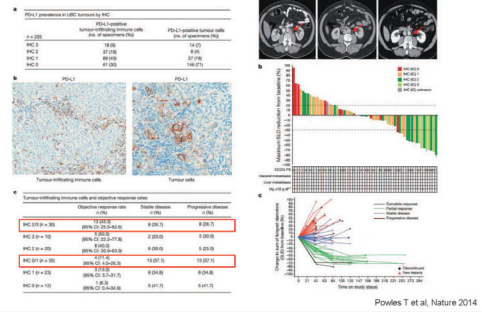
Selected concurrent chemotherapy regimens for TMT

Series	Treatment regimen	Outcomes
Cisplatin eligible		
Weiss et al. [93] and Rodel et al. [94]	Cisplatin 20mg/m ² /day i.v. given days 1-5 and 29-33 SFluorouracil 600mg/m ² /day i.v. given days 1-5 and 29-33 Concurrent radiotherapy	CR 88%, 5-year OS 74%, and BIS 92% (Weiss et al. [93]) and CR 87%, 5-year OS 67%, and BIS 54% (Rodel et al. [94])
Gagna et al. [95]	Cisplatin 35mg/m ² i.v. weekly Concurrent radiotherapy	CR 70%, 5-year OS 50%, and BIS 61%
Cisplatin ineligible		
James et al. [96]	SFluorouracil 500mg/m ² /day i.v. given days 1-5 and 16-20 Mitomycin 12mg/m ² i.v. day 1 Concurrent radiotherapy	5-year OS 48%. Improved locoregional control over radiotherapy alone 86% vs. 54% at 2 years, HR 0.68, P=0.03
Oh et al. [97]	Gemcitabine 27mg/m ² i.v. twice weekly Concurrent radiotherapy	CR 70%, 5-year OS 76%, and BIS 62%
Rodel et al. [98]	Carboplatin 65mg/m ² /day i.v. given days 1-5 and 29-33 Concurrent radiotherapy	CR 66%, 5-year OS 45%, and BIS not reported

BIS=bladder intact survival, CR=complete response, OS=overall survival, i.v.=intravenous.

Rose TL et al. Curr Opin urol 2015

MPDL3280A (anti-PD-L1) treatment leads to clinical activity in metastatic bladder cancer



Powles T et al. Nature 2014

박진성

Progression in surgical anatomy and technique after introduction of RARP

박진성

을지대학병원

Progress of RP technique

- Anatomical RRP (Walsh, 1979)
- First Laparoscopic RP (Schuessler, 1992)
- First RARP (Abbou, 2001)
- Veil of Aphrodite (Menon, 2006)
- Posterior reconstruction (Rocco, 2006)
- BN sparing (Gaston, 2007)
- Pubovesical complex sparing (Asimakopoulos, 2010)
- Retzius sparing (Galfano, 2010 and 2014)
- BN sling (Kojima, 2014)

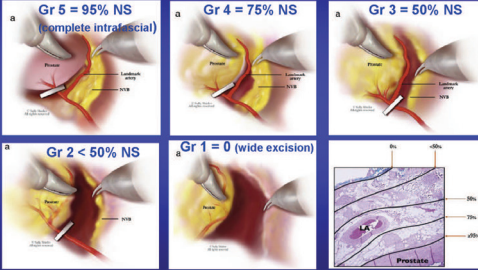
Surgical techniques to improve functional outcomes at RARP

- Preservation** (neurovascular bundle, bladder neck, puboprostatic ligament, pubovesical complex, Retzius sparing, etc.)
- Reconstruction** (posterior and/or anterior reconstruction, and/or reattachment of the arcus tendineus to the bladder neck, etc.)
- Reinforcement** (bladder neck plication and/or sling suspension, etc.)

Better understanding of anatomy

Kojima et al, Int J Urol, 2013

Visual clue of NVB preservation : landmark artery + fat strip over the prostate



Schatloff et al. Eur Urol, 2012

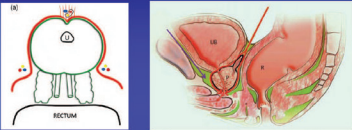
RISK-STRATIFIED APPROACH

- Significant diff. across different NS grades in terms of the % of pts. who had intercourse and returned to baseline SF (P < 0.001).
- Reported higher rates of intercourse (90.9% for grade 1 and 62% for grades 4 NS)
- Return to baseline sexual function (81.7% for grade 1 and 54.4% for grades 4 NS)
- The overall PSM rates for patients with NS grades 1, 2, 3 and 4 were 9.9%, 8.1%, 7.2% and 8.7% (P = 0.64).
- With increasing degree of NS, PSM rates were not significantly elevated; potency outcomes, however, were significantly better.

CONCLUSION

- NS-RP should be planned independently of preoperative potency status whenever technically and oncologically feasible.
- Optimal NS-RP should be planned using various preop. parameters such as PSA, GS, percentage of cancer in Bx, no. of (+) cores, presence of UNI vs BILAT. (+) cores (used as a surrogate for high-volume cancer or multifocality), clinical stage, findings of the eMRI for cancer localization, tumour vol., (+/- of EPE), and status of periprostatic tissue.
- Improved "trifecta outcomes" can be achieved by adoption of athermal, traction-free, risk-stratified, graded nerve sparing approach to preserve the neural networks.
- Innovative imaging techniques to incorporate real-time intraoperative imaging and nerve mapping methodologies to identify and preserve the CNs will play important role in guiding optimal NS approach.

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



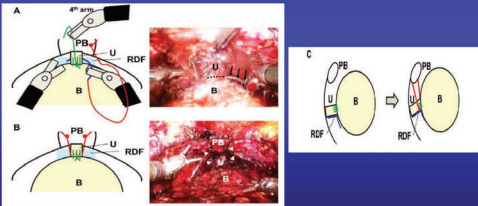
- Neurovascular bundles, puboprostatic ligaments, Aphrodite's veil, accessory pudendal arteries (beyond red line) are untouched.
- Immediate continence: 92% (first 100 cases) vs. 90% (100-200 case)
- Post-op 1 mo intercourse rate (potent patients < 65 yrs undergoing bilat. intrafascial NS): 40.4% vs. 40%
- Transfusions: 8% vs 4%, pT2 PSM rate = 22.4% vs. 10.1%

Galfano et al. Eur Urol, 2013

Radical Prostatectomy

Bladder Neck Sling Suspension During Robot-assisted Radical Prostatectomy to Improve Early Return of Urinary Continence: A Comparative Analysis

Yoshiyuki Kojima, Takashi Hamakawa, Yasuo Kubota, Soichiro Ogawa, Nobuhiro Haga, Keiichi Tozawa, Shoichi Sasaki, Yutaro Hayashi, and Kenjiro Kohri



RDF: reconstructed Denonvillier's fascia

Kojima et al. Urology, 2014

Table 2. Comparison of subjective (patient) and objective (quantitative) assessments of voiding and storage function and urinary leakage before and after robot-assisted radical prostatectomy between sling and no sling groups.

Variable	Preoperation	4 Wk	12 Wk	24 Wk
PVR (mL)				
Nonsling	18.6 (10.0, 36.0)	5.7 (0.0, 17.7)	12.1 (0.0, 21.4)	0.0 (0.0, 0.0)
Sling	12.8 (5.8, 36.7)	0.0 (0.0, 2.9)	0.0 (0.0, 0.0)	0.0 (0.0, 0.0)
Between 2 groups P value	n.s.	n.s.	n.s.	n.s.
1-hour pad test (g)				
Nonsling	—	15.5 (5.0, 93.3)	6.0 (1.0, 32.0)	1.5 (0.0, 10.75)
Sling	—	4.5 (1.8, 32.3)	5.0 (2.0, 33.0)	1.0 (0.0, 9.5)
Between 2 groups P value	—	P<0.05	n.s.	n.s.

Figure 2. Representative appearance of cystography during Valsalva maneuver 7 days after robot-assisted radical prostatectomy in nonsling (A) and sling (B) groups. The posterior urethrovaginal angle is similar in a patient in the sling group than that in a patient in the nonsling group.

→ BN sling suspension technique can improve the early return of continence after RARP.

Gross anatomy on MRI is also important in preoperative planning.

- 1) Apical shape, Base shape, SV 위치 및 크기
- 2) NVB formation
- 3) DVC 발달 정도
- 4) Ant. fibromuscular stroma, accessory pudendal vessel, etc.

Case 2

- Mar. 2013, Radical cystectomy
w/ orthotopic ileal neobladder formation
w/ super-extended pelvic LN dissection

Case 3

- Mar. 2010, Prostate sparing radical cystectomy
w/ orthotopic ileal neobladder formation
w/ standard pelvic LN dissection

구자현

Case 1

- CT (Apr. 2009)

Post TUR-BT status
Focal intraluminal filling soft tissue mass in right far distal ureter
→ mild Rt. hydronephrosis
→ enlarged right obturator LN with suspicious focal internal low attenuation foci.

Case 1

- Oct. 2007, Prostate sparing radical cystectomy
w/ orthotopic ileal neobladder formation
w/ standard pelvic LN dissection

Case 3

- CT (Apr. 2014)

No demonstrable recurrent lesion or distant metastasis
Otherwise, no significant change since the last study

Case 3

- MRI (May. 2014)

1. A small polypoid lesion in the neobladder neck anterior aspect.
About 2.5cm sized T2 low SI lesion involving right prostate gland including peripheral zone with diffusion restriction and early enhancement
→ TCC involvement, probably.

2. No significant LNs.

홍범식

Case 1

- Aug, 2015 TRUS-Bx

7 core-biopsy due to small prostate size

Adenocarcinoma, GS 7(3+4)/10 (#1)
(tumor length/core length: 0.5/1.2cm)
Adenocarcinoma, GS 8(4+4)/10 (#2)
(tumor length/core length: 0.9/1.1cm)
Adenocarcinoma, GS 8(4+4)/10 (#3)
(tumor length/core length: 0.6/1.0cm)
Adenocarcinoma, GS 7(4+3)/10 (#4)
(tumor length/core length: 0.3/1.0cm)
Adenocarcinoma, GS 7(4+3)/10 (#5)
(tumor length/core length: 0.3/1.0cm)
Adenocarcinoma, GS 9(5+4)/10 (#6)
(tumor length/core length: 0.2/1.0cm)
Adenocarcinoma, GS 9(5+4)/10 (#7)
(tumor length/core length: 0.4/1.2cm)

All core prostate cancer, GS 9(5+4)

Case 2

- CT (Mar. 2013)

1. About 3.0*3.1cm measured broad neck polypoid mass at Lt. lateroposterior wall of urinary bladder (adjacent lt. UVJ)
→ large Bladder TCC, more likely.
→ Involvement of tumor into full thickness of involvement bladder wall suspected

2. Grossly no significant LNs

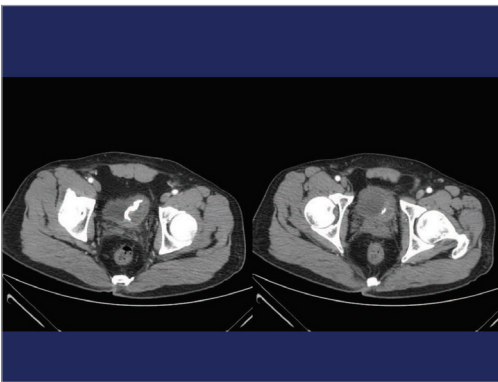
Symposium I: Radical Cystectomy and Urinary Diversion

Case Discussion

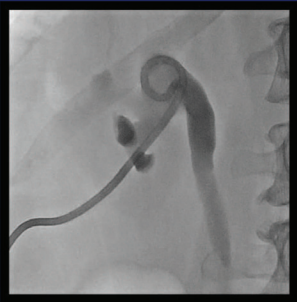
Bumsik Hong
Univ. of Ulsan College of Medicine
Asan Medical Center

55/M

- Chief complaint;
total painless grosshematuria
- Present illness
grosshematuria starting 1 year ago
TURBT was done for large, solid bladder tumor on left side at previous hospital



LEFT PCN (2011.10.04) AT AMC

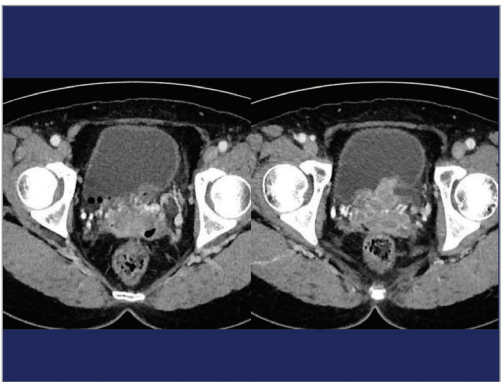


[2011/10/05 - CT, Urography]
CONCLUSION :

Enhancing wall thickening in the left side of the bladder.
Perivesical tissue invasion.
LN enlargement in left external iliac, common iliac, and left paraaortic area.
--> r/o bladder cancer (T3a N2 Mx).

[2012/01/10 - CT, Urography]
Subtle enlarged paraaortic lymph node in the left side of the aorta, suggestive of reactive hyperplasia or stable disease of lymph node metastasis.

No visible lymphadenopathy in the pelvic cavity.



Neoadjuvant chemotherapy
(2014.10~2015.01)

- Gemcitabine/cisplatin chemotherapy, 4 cycles
- 3 week interval between each cycle
- Each cycle consists of:
 - Gemcitabine 1500 mg i.v.
 - Cisplatin 110 mg i.v.

Pathology

- INFILTRATING UROTHELIAL CARCINOMA
- HIGH GRADE (WHO GRADE 3/3)
- invasion into subepithelial connective tissue and muscularis propria.
- no lymphovascular invasion.

Pathology

- Chronic cystitis, mild, with scar.
- Negative for malignancy.

[2012/01/13 - Bladder Tumor]
- No residual infiltrating urothelial carcinoma, urinary bladder (s/p transurethral resection and chemotherapy for infiltrating urothelial carcinoma, high grade).
- METASTATIC UROTHELIAL CARCINOMA, LYMPH NODES (3/43)
(left paraaortic LN: 0/17, left common iliac LN: 1/8, left external iliac LN: 2/3, right external iliac LN: 0/4, right common iliac LN: 0/1, right pelvic LN: 0/2, right paracaval LN: 0/5, left pelvic LN: 0/3)
(largest metastatic tumor size: 13 mm, without extranodal extension).
- UROTHELIAL CARCINOMA IN SITU, LEFT LATERAL WALL OF URINARY BLADDER, 1.5 cm IN GREATEST DIMENSION.

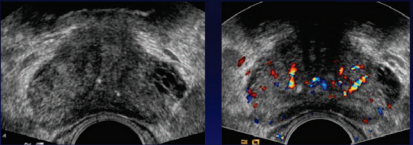
53/F

- Chief complaint
 - Suprapubic pain starting 1 year ago
- Present illness
 - 2013.7 suprapubic pain 시작, 타병원 medication 에도 호전 없어 내원.
 - Pain 은 voiding 과 관련없으며 지속적, 뻣근하고 묵직, Visual Analog Score 5-10

정창욱

Case 1

- Apr. 2004, TRUS-Bx: adenocarcinoma,
Gleason score 8 (4+4), #1 (0.2/1.1cm)
Gleason score 6 (3+3), #4 (0.3/0.9cm)



Case 1

Low risk	Diagnostic PSA < 10.0 ng/mL and highest biopsy Gleason score ≤ 6 and clinical stage T1c or T2a
Intermediate risk	Diagnostic PSA ≥ 10 but < 20 ng/mL, or highest biopsy Gleason score = 7 or clinical stage T2b
High risk	Diagnostic PSA ≥ 20 ng/mL or highest biopsy Gleason score ≥ 8 or clinical stage T2c/T3

Table. D'Amico risk stratification for clinically localized prostate cancer

- 1) Sexually active 65 year old man
- 2) PSA 10.8
- 3) Biopsy Gleason score 8
- 4) Clinical stage T2a
- 5) MRI: not available
- 6) Preoperative IIEF-5: 17(mild ED)

Case 1

● Final pathology

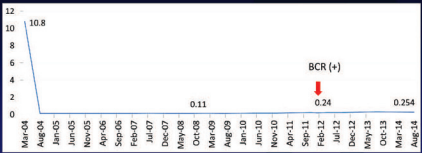
Prostate, radical prostatectomy:

- Adenocarcinoma, Gleason's score 7(4+3)/10, bilateral lobes with 1) tumor volume: 20%
- 2) confinement to prostatic parenchyme
- 3) no involvement of seminal vesicle and vas deference.
- 4) perineural invasion
- 5) tumor involvement of apex resection margin
- 6) clear base and vas deferential resection margins

Case 1

● OPD f/u

- # Incontinence: Pad free since postop 1 mo
- # Erection: Intracavernosal injection on demand at postop 9 mo
- 60~70% erection on oral medication at 1 yr
- # Biochemical recurrence (+) at postop 8yr + 9 mo



Case 1

[MICROSCOPIC DESCRIPTION]

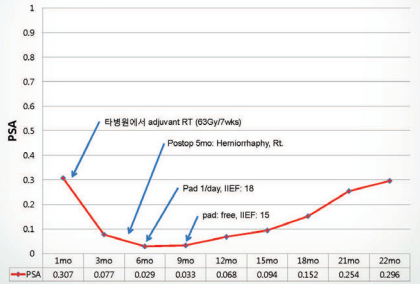
- a) tumor size; 3.3 x 3.1 x 1.7 cm
- b) site; peripheral > central zone, right < left, posterior, superior > inferior
- c) histologic type; acinar
- d) Gleason's score; 9 (most common; 4, second most common; 5)
- e) tumor volume; V2b (>5 cm3)
- f) presence of PIN; present(++), high grade and low grade
- g) growth pattern; expanding and infiltrative
- h) lymphatic invasion; absent
- i) vascular invasion; absent
- j) perineural invasion; present (+++)
- k) prostatic urethral invasion; absent
- l) extraprostatic extension; present(++), perineural space of neurovascular bundles
- m) seminal vesicle invasion; present(left)
- n) surgical margin involvement; present, posterior, left (width of involvement: 0.2 cm)
- o) multiplicity; absent
- p) TNM pathologic stage; pT3 (b)
- q) lymph node metastasis; absent (0/6), right obturator; 0/2, left obturator; 0/4

[DIAGNOSIS]

- 1. Prostate, radical prostatectomy(#1); Adenocarcinoma, Gleason's score 9 (4+5).

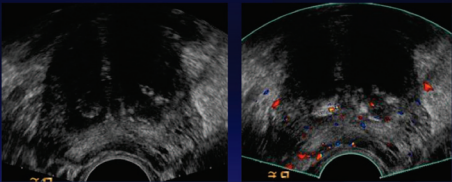
Case 1

Postop PSA



Case 2

- Apr. 2010, TRUS-Bx: adenocarcinoma, Gleason score 6 (3+3), #4 (0.4/1.5cm)



Case 2

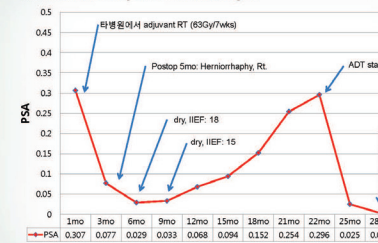
Low risk	Diagnostic PSA < 10.0 ng/mL and highest biopsy Gleason score ≤ 6 and clinical stage T1c or T2a
Intermediate risk	Diagnostic PSA ≥ 10 but < 20 ng/mL or highest biopsy Gleason score = 7 or clinical stage T2b
High risk	Diagnostic PSA ≥ 20 ng/mL or highest biopsy Gleason score ≥ 8 or clinical stage T2c/T3

Table. D'Amico risk stratification for clinically localized prostate cancer

- 75 year old man with no sexual activity
- PSA 21.7 ng/ml
- Biopsy Gleason score 6
- Clinical stage T1c
- MRI: Visible tumor at Lt apex, no EPE, no SVI
- Preoperative IIEF-5: 3

Case 1

• ADT: GnRH antagonist + antiandrogen



- 이후 F/U loss

Case 2

- PSA: 9.0
- TRUS: 32.7cc
- DRE: soft, symmetric, not fixed
- Prostate biopsy
[MICROSCOPIC DESCRIPTION]
 - a) size; involved up to 0.5 cm / 0.8 cm of total length
 - b) site; Rt. L5, R5
 - c) Gleason score; 8 (4 + 4)
 - d) lymphatic invasion; absent
 - e) vein invasion; absent
 - f) perineural invasion; present
 - g) presence of PIN; absent
- [DIAGNOSIS]
 - Prostate, needle biopsy(Rt1-6, Lt1-6); Adenocarcinoma, Gleason score 8 (4 + 4).
- IPSS: 21 (voiding 17+storage 4)/ QoL 4
- UDS
 - Pressure flow: 10.0ml/s-35cc-50cc
 - BOO grade I
- IIEF: 14

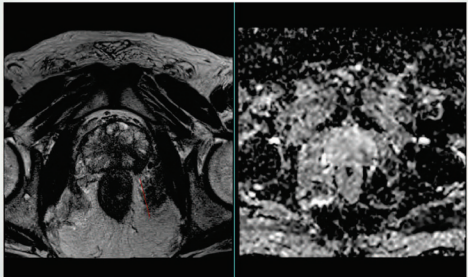
홍성후

Case 1

- PSA: 28.9 ng/mL
- TRUS: 21cc
- DRE ; hard nodule on Lt. lobe, not fixed
- Prostate biopsy
[MICROSCOPIC DESCRIPTION]
 - a) size; involved up to 0.3 cm / 0.8 cm of total length
 - b) site; L3, L4, L5
 - c) Gleason score; 8 (5 + 3)
 - d) lymphatic invasion; absent
 - e) vein invasion; absent
 - f) perineural invasion; present
 - g) presence of PIN; absent
- [DIAGNOSIS]
 - Prostate, needle biopsy(Rt1-6, Lt1-6); Adenocarcinoma, Gleason score 8 (5 + 3).
- IPSS: 8 (voiding 2+storage 6)/ QoL 2
- UDS
 - Pressure flow: 10.5ml/s-27cc-50cc
 - BOO grade I
- IIEF: 23

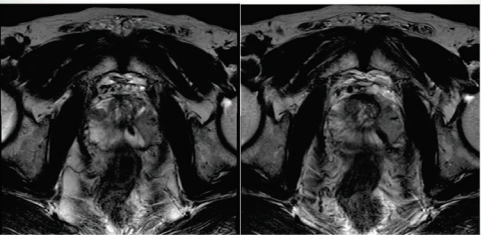
Case 1

- MRI Prostate
 - Prostate cancer in Lt peripheral zone of the prostate : T3aNOmx



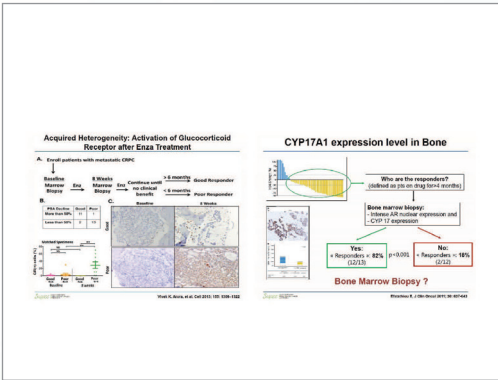
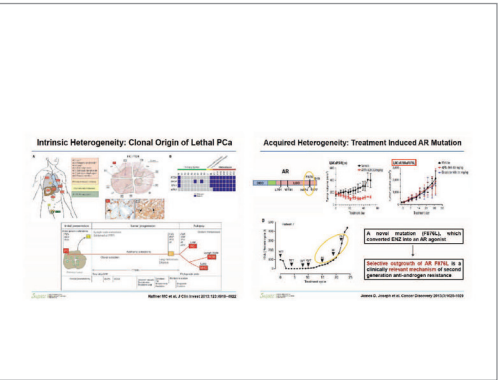
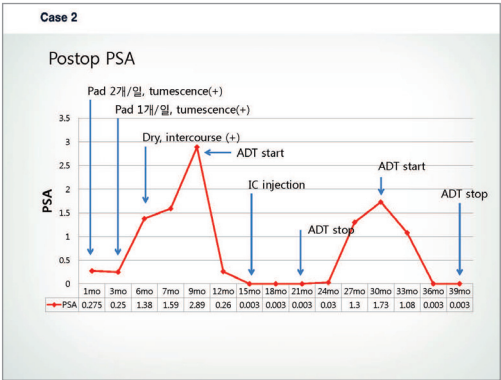
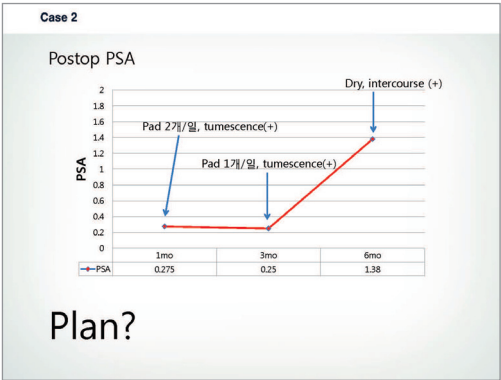
Case 2

- MRI Prostate
 - Prostate Ca. at the apex and mid portion of Rt. prostate gland, suggesting T2NOmx.

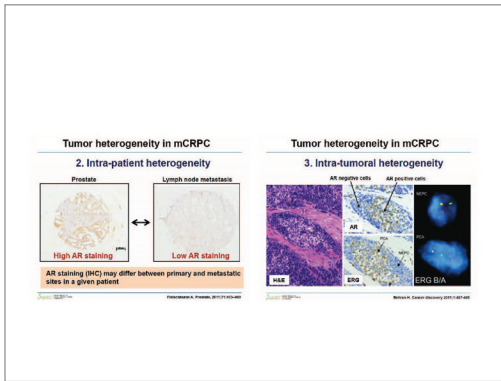
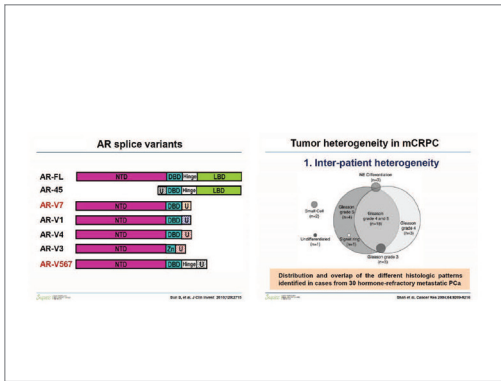
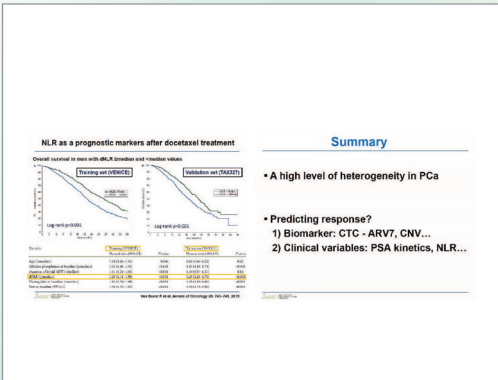
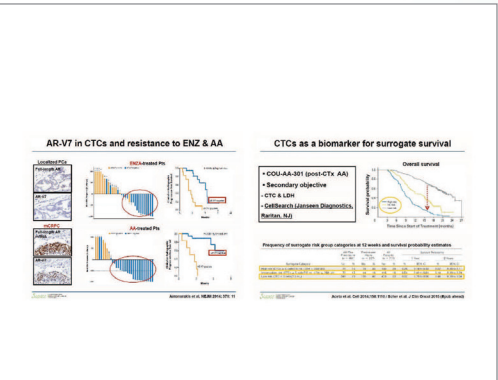
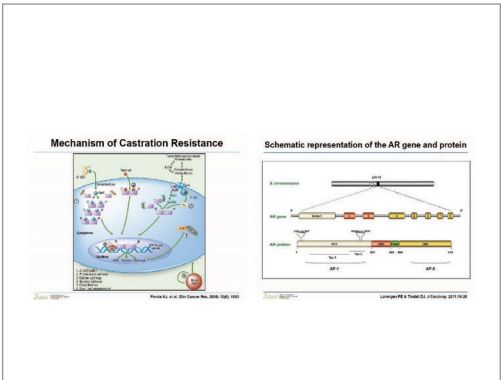
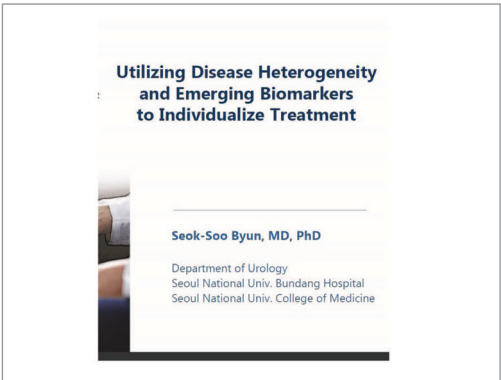


Case 2

- [MICROSCOPIC DESCRIPTION]
 - a) tumor size; 2.0 x 1.8 x 1.3 cm
 - b) site; peripheral / transitional / central zone, right > left, anterior < posterior, superior < inferior
 - c) histologic type; acinar
 - d) Gleason's score; 9 (most common; 4, second most common; 5)
 - e) tumor volume; V2a (1-5 cm3)
 - f) presence of PIN; present (++) (high grade)
 - g) growth pattern; expanding and infiltrative
 - h) lymphatic invasion; present (++)
 - i) vascular invasion; absent
 - j) perineural invasion; present (+++)
 - k) prostatic urethral invasion; absent
 - l) extraprostatic extension; present, perineural space of neurovascular bundles
 - m) seminal vesicle invasion; absent
 - n) surgical margin involvement; present, apex, right, anterior & posterior (width of involvement: less than 0.3 cm)
 - o) multiplicity; absent
 - p) TNM pathologic stage; pT3 (a)
- [DIAGNOSIS]
 - Prostate, radical prostatectomy; Adenocarcinoma, Gleason's score 9 (4+5).



변석수



2015 제2차 비뇨기종양학회 학술집담회 및 송년회

[2015년도 제2차 비뇨기종양학회 학술집담회 및 송년회]

대한비뇨기종양학회 회원 여러분 안녕하십니까?
다사다난했던 2015년이 어느덧 아득한 추억 속으로 빠져들고 있습니다. 한 해를 되돌아보고 보다 성숙한 새해를 맞이하기 위한 학술 집담회 겸 송년 모임에 참여하셔서 뜻 깊은 자리를 만들어 주시기를 부탁드립니다. 아울러 동절기에 건강 유의하시고 덕내 여유로움이 함께 하기를 진심으로 기원합니다.

일정안내

- 일시: 12월 8일(화) 오후 6-9시
- 장소: 제일약품 본사 12층 대강당 (서울시 서초구 반포동745-5 번지)

17:50-18:00	개회사 및 인사말	대한비뇨기종양학회 김형진 회장
18:00-18:20	Management of complications after radical prostatectomy	좌장: 김형진 (전북의대) 연자: 하홍구 (부산의대)
18:20-19:00	Case Discussion 진행: 하홍구 (부산의대) Panels: 권동득 (전남의대), 송재만 (연세의대), 전성수 (성균관의대), 최한용 (성균관의대)	좌장: 김형진 (전북의대)
19:00-19:20	축하연 - 장성구 전임회장 “여강의 꿈”시집 발간 - 대한비뇨기종양학술지 한국연구재단 등재후보지 선정 - 대한비뇨기종양학회 진료지침 특별위원회 개발 전립선암, 신장암 및 방광암 진료지침 온라인 등재	
19:20-19:30	폐회사	대한비뇨기종양학회 김형진 회장
19:30-21:00	송년회	

대한비뇨기종양학회 회장 김 형 진



Q The 14th KUOS Multidisciplinary Conference

- 일시: 2016년 3월 26일 (토)
- 장소: 차의대 바이오컴플렉스

08:30-09:00	Registration	
09:00-09:05	President’s Welcome	대한비뇨기종양학회장 김형진
09:05-09:10	Congratulatory Remarks	대한비뇨기과학회장 주명수
09:10-10:30	Symposium (I): RCC: Updates	
	Variant histologic forms of RCC	
	MR imaging in RCC	
	Renal biopsy: when should it be used?	
	Immunotherapy with programmed cell death inhibitor drugs: who achieve durable response?	
10:30-10:50	Coffee break	
10:50-12:10	Consensus meeting (I): Localized and locally advanced RCC	
	Optimal management for T1b renal cancer in patients with normal GFR	
	Management of adrenal gland in patient with RCC	
	The role of lymphadenectomy in patient with RCC	
	Panel Discussion 증례 진행: 패널:	
12:10-13:40	Luncheon Symposium 및 이사회 (차기 회장 선거) (사진 촬영)	
	Initial chemotherapy in metastatic hormone-sensitive prostate cancer Noel Clarke (Department of Urology, Christie Clinic, Manchester, UK)	
13:40-15:00	Symposium (II): Updates of prostate cancer	
	Prognostic significance of the updated International Society of Urological Pathology (ISUP) grading system	
	MR-fusion biopsy: usefulness & clinical application	
	The role of PET-CT in prostate cancer	
	Role of hormonal therapy in adjuvant and salvage radiotherapy	
15:00-15:30	Invited Lecture	
	Role of androgen signaling in renal cell carcinoma	Isaac Y. Kim (New Jersey Cancer Center)
15:30-15:50	Coffee break	

15:50-17:10	Consensus meeting (II): metastatic prostate cancer
	Oligo-metastatic prostate cancer: Definition and treatment Chemotherapy in CRPC CRPC guideline
	Panel discussion: 증례 진행 패널:
17:10-17:40	총회

MEMO

Handwriting practice lines consisting of 20 horizontal dashed lines.