대한비뇨기종양학회

KUOS 뉴스레터

The Korean Urological Oncology Society

Vol. No 2016_2

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학술대회 초대의 글

비뇨기종양학회 회원 여러분 안녕하십니까?

올해는 유난히도 빨리 여름이 시작되어 벌써 더위가 성큼 다가왔습니다.
2016년 8월 27일 부산 해운대 백병원에서 개최되는 제29회 대한비뇨기종양학회 정기학술대회에 회원 여러분을 초대하게 되어 기쁘게 생각합니다.

작년에 시행하려다 메르스 발생으로 못했던 워크숍을 비뇨기종양학회의 자문위원, 원로회원과 젊은 회원을 모시고 5월 말에 진료지침 워크숍 을 전북 남원에서 성황리에 마쳤습니다. 열띤 토론과 함께 회원 여러분들의 학회에 대한 관심과 열정을 확인할 수 있었습니다. 지면으로나마 감사를 드립니다.

우리 비뇨기종양학회의 정기 학술대회는 매년 새로운 지식과 정보, 연구 결과를 제공하고 공유하는 장으로서, 학문적 토의와 논쟁을 통한 발전의 공간으로서 그 역할을 충실히 해왔습니다. 지난 학술대회를 통해 회원들의 적극적인 참여와 노력은 비뇨기종양 연구 및 학문적 발전의 밑거름으로써 우리 학회의 가장 큰 자랑이자 역사라고 자부합니다.

이번 학술대회는 비뇨기종양 전반에 걸쳐 국내외에서 활발히 활동하고 연구하시는 분들을 좌장 및 연자, 패널로 모시고 비뇨기종양 분야의 이슈를 토론하고 정리할 수 있는 시간이 되실 것이라고 생각합니다. 또한 Podium Session은 지난 1년 동안 회원 여러분들이 비뇨기종양 분야에 불철주야 연구하신 성과를 발표하고 서로 토의할 수 있는 유익한 자리가 되리라 생각합니다.

이번 학술대회가 유익한 정보를 서로 공유하며 학문적 발전을 도모하고, 회원 여러분들의 소통과 교제의 장이 될 수 있기를 바라며 회원 여러분들의 적극적인 성원과 참여를 부탁 드립니다. 아울러 무더운 여름철에 회원 여러분의 가정에 건강과 행복이 함께하시길 기원합니다.

감사합니다.

2016년 6월
대한비뇨기종양학회 회장 김 형 진

대한비뇨기종양학회
서울특별시 강남구 일원로 81 (일원동, 삼성서울병원암병원6층 비뇨기과교수연구실)

2016년 제29회 대한비뇨기종양학회 정기학술대회

- 일시: 2016. 8. 27. 토
- 장소: 해운대 백병원

08:30-09:00	Registration	
09:00-09:05	President's Welcome	대한비뇨기종양학회 회장 김형진
09:05-09:10	Congratulatory Remarks	대한비뇨기과학회 회장 주명수
09:10-09:15	Congratulatory Remarks	인제의대 교수 박석산
09:15-10:05	Podium Session I: Prostate Cancer	
10:05-10:35	Special Lecture	
	Single Cell Genomics	
10:35-10:50	Coffee Break	
10:50-12:00	Symposium I : Management of Bladder Cancer	
	1) Emerging Therapies for Non Muscle Invasive Bladder Cancer	
	2) Risk-based Neoadjuvant Chemotherapy in MIBC?	
	3) Future Directions in Bladder Cancer Immunotherapy	
	Panel Discussion: Case Based Approach	
12:00-13:10	진료지침 발간 기념식 및 전체 사진 촬영	
	Lunch	
13:10-13:30	연수보고회	
13:30-13:50	Project 2015 Report / 2016 Proposal	
13:50-14:40	Podium Session II: Bladder and Renal Cancer	
14:40-15:00	Coffee Break	
15:00-15:50	Podium Session III: Prostate Cancer	
15:50-16:50	Symposium II : Management of Prostate Cancer	
	1) Active Surveillance for Prostate Cancer: Good Idea or Lost Opportunity?	
	2) Treatment for Pelvic Nodal Relapse after Radical Prostatectomy	
	3) Chemotherapy in Hormone-na ve Prostate Cancer?	
	4) Management of Non-metastatic CRPC	
16:50-17:20	2016 KUOS Annual Business Meeting	
17:20-17:30	학술상 시상 및 폐회사 (Adjourn)	

2016년 제1차 비뇨기종양학회 학술집담회

[2016년도 제1차 비뇨기종양학회 학술집담회]

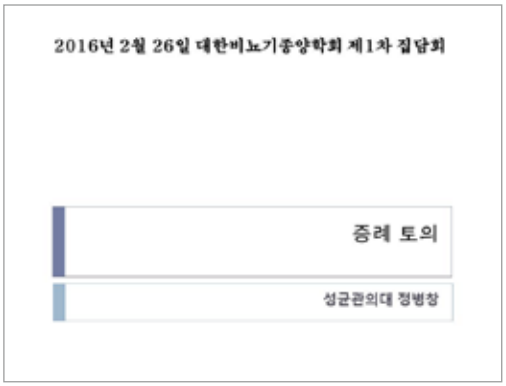
일 정 안 내

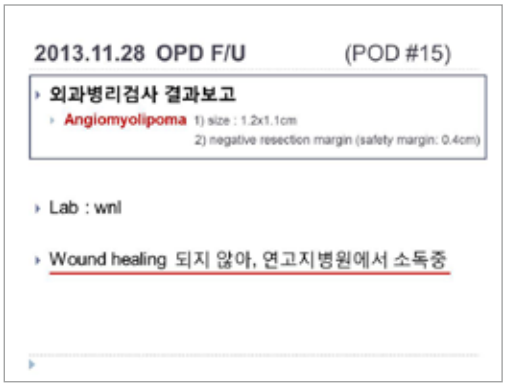
- 일시 : 2월 26일(금) 17:50-19:00
- 장소 : 경북대학교병원 6병동 10층 대강당

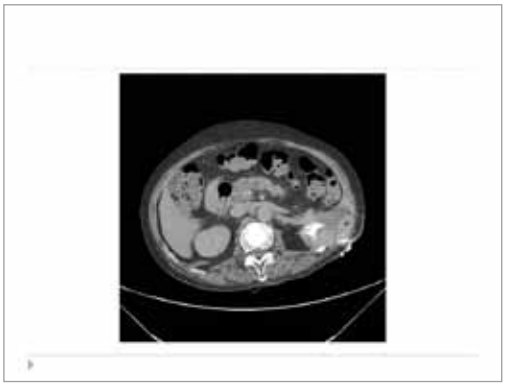
17:50-18:00	개회사 및 인사말	대한비뇨기종양학회 김형진 회장
18:00-18:20	Management of complications after surgical treatment of RCC	좌장: 김형진 (전북의대) 연자: 한준현 (한림의대)
18:20-19:00	Case Discussion Panels: 강석호 (고려의대), 서성일 (성균관의대), 전승현 (경희의대), 한준현(한림의대)	진행: 정병창 (성균관의대)
19:00	폐회사	대한비뇨기종양학회 김형진 회장

대한비뇨기종양학회 회장 김 형 진

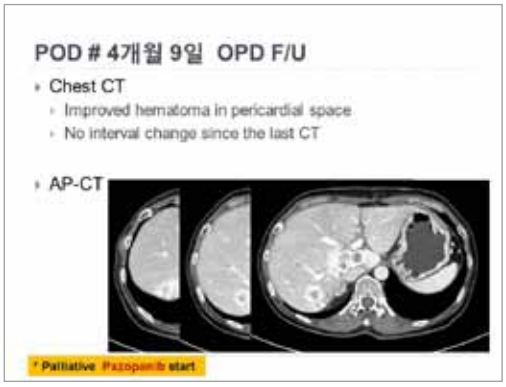
정병창


2016년 2월 26일 대한비뇨기종양학회 제1차 집담회
증례 토의
성균관의대 정병창


2013.11.28 OPD F/U (POD #15)
외과병리검사 결과보고
Angiomyolipoma 1) size : 1.2x1.1cm
2) negative resection margin (safety margin: 0.4cm)
Lab : wnl
Wound healing 되지 않아, 연고지병원에서 소독중

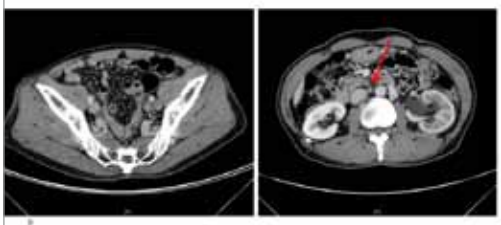



F / 54
Chief complaint
fatigue, anorexia
(onset: 1 month ago)
Present illness
1개월 전부터 피곤하고, 밥맛 없는 증상을 호소
외부병원 복부 초음파 검사에서 Lt renal mass 발견됨
복부CT 검사에서 r/o Lt RCC 소견으로 본원 내원함


POD # 4개월 9일 OPD F/U
Chest CT
Improved hematoma in pericardial space
No interval change since the last CT
AP-CT
Palliative Pazopanib start

Case 4

- M/68, Lt distal ureter tumor
- Lt laparoscopic nephroureterectomy with LN dissection



Autotransplantation of rt. kidney

M / 75

Chief complaint

Incidentally detected renal mass, left (onset: 2 month ago)

Present illness

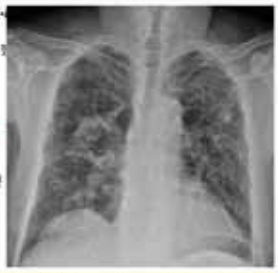
2013.08.28 외부병원에서 시행한 TRUS Bx.에서 prostate cancer
(PSA 8.3, adenocarcinoma, Right 3core positive, GS 3+4) 진단받음

staging w/u.으로 시행한 AP-CT에서 Lt renal mass 발견되어 본원 내원함

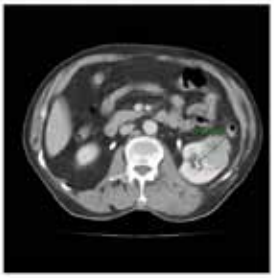
* prostate cancer에 대해서는 외부병원에서 호르몬 치료만 받기로함

Past surgico-medical history

- HTN/DM/Tbc/Hepatitis (-/-/-/-/-)
- Pneumoconiosis
  - 30년 전, 탄광에서 광부로 일함
- Operation history (+)
  - 기흉수술 7회
  - 2013년 우측 폐 부분절제술
- Social Hx.
  - Smoking (-) : 15년 전 금연
  - Alcohol (-)
- Family Hx.
  - None

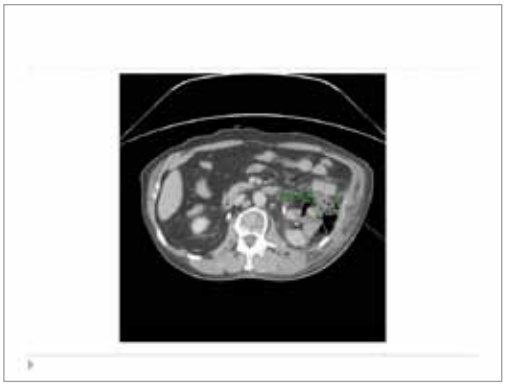


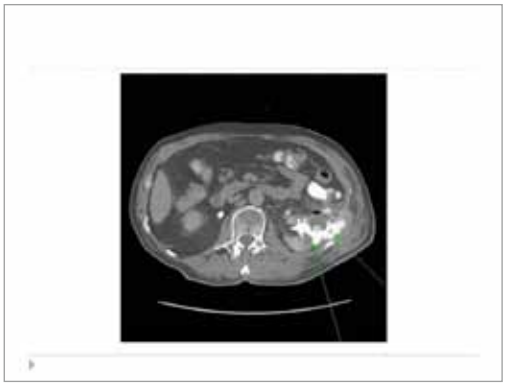
R/O PMF(progressive massive fibrosis) with underlying pneumoconiosis



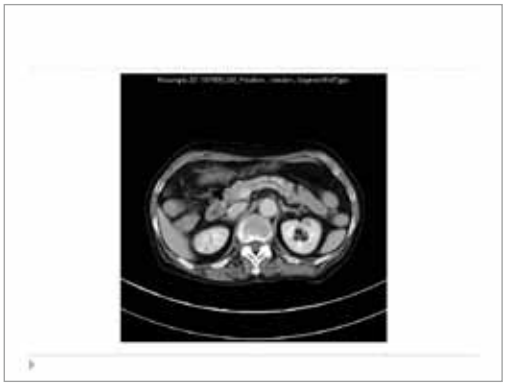
2013.12.04 s/p US guided kidney Bx.

s/p CT guided percutaneous RFA
(under mask with TIVA)



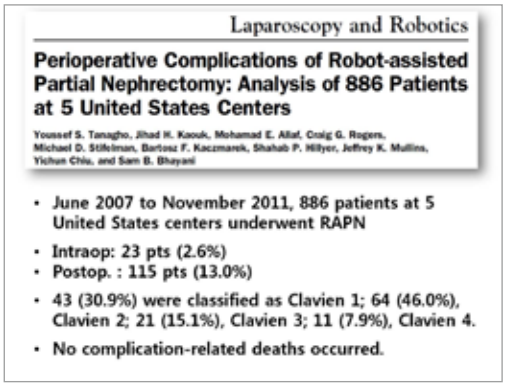



F / 76
Chief complaint
Intermittent LUQ pain
(onset: 2 month ago)
Present illness
2개월 전부터 간헐적으로 좌측 상복부 통증을 호소
외부병원에서 복부 초음파 검사 및 CT검사 시행 후 Lt renal mass
발견되어 본원 내원함



한준현


Management of complications after surgical treatment of RCC
Hallym University Dongtan Sacred Heart Hospital
Han, Jun Hyun M.D., Ph.D.

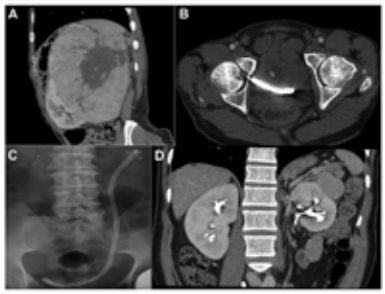

Laparoscopy and Robotics
Perioperative Complications of Robot-assisted Partial Nephrectomy: Analysis of 886 Patients at 5 United States Centers
Youssef S. Tanagho, Jihad H. Kaouk, Mohamad E. Allaf, Craig G. Rogers, Michael D. Stifelman, Bartosz F. Kaczmarek, Shahab P. Hillyer, Jeffrey K. Mullins, Yichun Chiu, and Sam B. Bhayani
• June 2007 to November 2011, 886 patients at 5 United States centers underwent RAPN
• Intraop: 23 pts (2.6%)
• Postop. : 115 pts (13.0%)
• 43 (30.9%) were classified as Clavien 1; 64 (46.0%), Clavien 2; 21 (15.1%), Clavien 3; 11 (7.9%), Clavien 4.
• No complication-related deaths occurred.

Complications After Robotic Partial Nephrectomy at Centers of Excellence: Multi-Institutional Analysis of 450 Cases

Gregory Spana, Georges-Pascal Haber,* Lori M. Dulabon, Firas Petros, Craig G. Rogers, Sam B. Bhayani,* Michael D. Stifelman† and Jihad H. Kaouk‡,§

- A total of 450 consecutive robotic assisted partial nephrectomies between June 2006 and May 2009.
- Overall complication 71 patients (15.8%)
- Intraoperative : 8(1.8%)
- Postoperative : 65 (14.4%)
- Conversion to RN: 7 (1.6%)

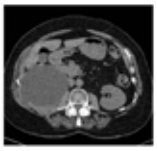
Prolonged Urinary Leakage After Partial Nephrectomy: A Novel Management Pathway



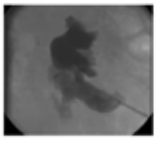
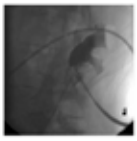
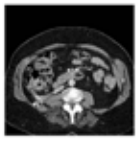
UROLOGY 83: 485e488, 2014

Glue ablation of a late-presentation urinary fistula after partial nephrectomy

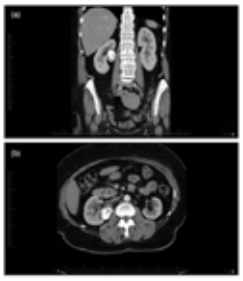
The British Journal of Radiology, 82 (2009), e248-e248



- A 57-yrs-woman, an right lower pole partial nephrectomy for clear cell RCC.
- After 1 yr , a 10 cm urinoma anterior to the rt kidney compressing the UPJ and upper ureter.
- PCN, D-J stent → continuous drainage
- Under LA and fluoro, Histoacryl glue (B Braun, Germany) was injected using a catheter. 6 ml of a 50:50 Histoacryl:lipiodol mixture

Malrotated kidney as a complication of partial nephrectomy



53-yr- woman c **DM, HT**
L assisted OPN

CT : **48 mm, posterior, central & endophytic** in RK

Complete mobilization of the right kidney and the operation was otherwise routine.

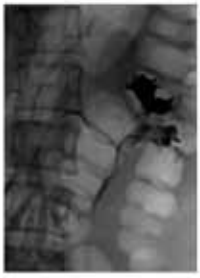
Urine leak requiring ureteric stent POD 5. Discharged on POD 9.

Hemorrhage

At different points during the case

- Hilar dissection
- Tumor resection
- Clamping removal
- Immediate or delayed posop period

Arterio-caliceal fistula and superselective embolization




Bowel injury

- Can be a **serious complication**, particularly **if unrecognized.**
- **Incidence** of laparoscopic bowel injury during urologic surgery was **0.13%** (266/205,969 cases),
- of which, **69% were unrecognized** at the time of surgery.

Rhabdomyolysis

- Due to **compression** related to **prolonged positioning.**
- Risk factors include **male sex, high body mass index, prolonged operative times, and the lateral decubitus position.**
- Suspected when a patient reports **discrete musculoskeletal pain** immediately upon recovering from anesthesia.

Rhabdomyolysis

- **acute renal failure (occurring in 4%-33% of patients), compartment syndrome, cardiac dysrhythmias via electrolyte abnormalities, and DIC.**
- Management includes **iv fluid hydration** with the initiation of sodium bicarbonate therapy for **urine alkalinization** in order to prevent myoglobin deposition in the glomeruli and progressive nephropathy.

Conclusions

- **Partial nephrectomy remains a challenging operation that requires considerable experience.**
- **PN is a time sensitive procedure that requires more than 1 pair of skilled hands (bedside vascular control and suction).**
- **As a result, maximizing the success of partial nephrectomy is important.**

The 14th KUOS Multidisciplinary Conference

http://www.kuos.or.kr

The 14th KUOS Multidisciplinary Conference

일시: 2016년 3월 26일(토) 08:30-17:40
장소: 차의대 바이오컴플렉스
평점: 대한의사협회 4점

안녕하십니까?

2016년 3월 26일 차의대 바이오컴플렉스에서 개최되는 14회 Multidisciplinary Conference에 여러분을 초대합니다.

Multidisciplinary Conference는 지난 10여년 간 비뇨기종양의 진단 및 치료에 대해 여러 과 선생님들을 모시고 깊이 있는 토론의 장으로서 발전해왔습니다. 올해에도 전립선암과 신장암을 주제로 최신지견과 생동감 있는 토론이 이루어지도록 준비하였습니다.

이번 Conference는 "RCC: updates", "localized and locally advanced RCC", "updates of prostate cancer", 및 "metastatic prostate cancer" 라는 주제로 전문지식을 넓히고 각 과 선생님들과 함께 실제 증례를 중심으로 열띤 학술 토론의 장이 될 것을 기대합니다.

특히 해외연자로 영국의 Noel Clarke 교수가 호르몬-순응 전이성 전립선암에서의 초기항암치료에 대한 최신지견을, 미국의 Isaac Y. Kim 교수가 신장암에서 androgen signaling의 역할에 대한 최신지견을 발표해 주실 예정입니다.

14회를 맞이하는 Multidisciplinary Conference에 여러 저명하신 교수님들을 초빙하여 우리 대한비뇨기종양학회 회원들과 교류 및 공동연구의 방향을 모색하고자 합니다. 이번 학술대회를 계기로 비뇨기종양을 연구하시는 여러 과 선생님들의 학술적 교류가 더욱 활발해지는 계기가 되기를 기원합니다. 경험이 많으신 회원님들의 적극적 참여와 지도를 부탁 드립니다.

2016년 한해도 회원 여러분들의 건강과 발전이 함께하시기를 기원합니다.

대한비뇨기종양학회 회장 김 형 진

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** — 좌장: **김홍섭** (건국의대) / **성경탁** (동아의대)
1. Variant histologic forms of RCC — **문경철** (서울의대)
2. MR imaging in RCC — **성득제** (고려의대)
3. Renal biopsy: when should it be used? — **황의창** (전남의대)
4. Immunotherapy with programmed cell death inhibitor drugs: who achieve durable response? — **김범석** (서울의대)

10:30-10:50 Coffee break

10:50-12:10 **Consensus meeting (I): Localized and locally advanced RCC** — 좌장: **권동득** (전남의대) / **송기학** (충남의대)
1. Optimal management for T1b renal cancer in patients with normal GFR
2. Management of adrenal gland in patient with RCC — **강성구** (고려의대)
3. The role of lymphadenectomy in patient with RCC — **김선일** (아주의대)
Panel Discussion — **이동현** (이화의대)
증례 진행: **강성구** (고려의대)
패널: **김범석, 김선일, 문경철, 성득제, 황의창**

12:10-13:40 **Luncheon Symposium 및 이사회** — 좌장: **김형진** (전북의대)
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** — 좌장: **박동수** (차의대) / **박홍석** (고려의대)
1. Prognostic significance of the updated International Society of Urological Pathology (ISUP) grading system — **권기영** (성균관의대 병리과)
2. MR-fusion biopsy: usefulness & clinical application — **이학종** (분당서울대병원 영상의학과)
3. The role of PET-CT in prostate cancer — **민정준** (전남의대 핵의학과)
4. Role of hormonal therapy in adjuvant and salvage radiotherapy — **김태환** (경북의대)

15:00-15:30 **Invited Lecture** — 좌장: **조진선** (한림의대)
Role of androgen signaling in renal cell carcinoma — **Isaac Y. Kim** (New Jersey Cancer Center)

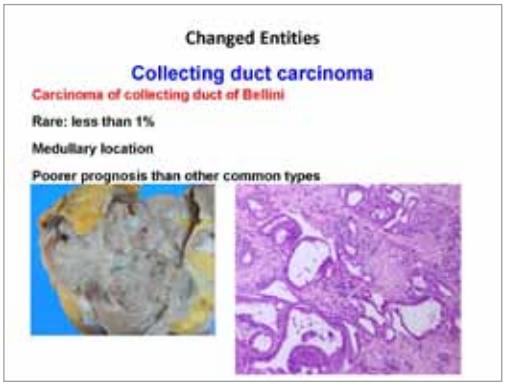
15:30-15:50 Coffee break

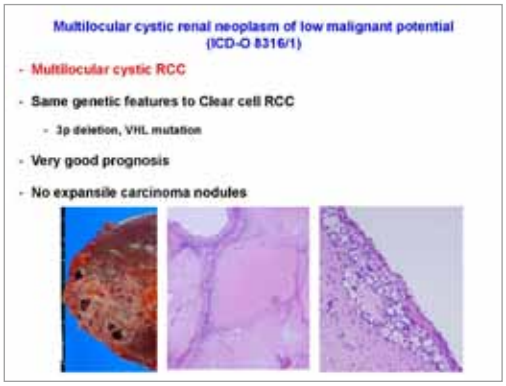
15:50-17:10 **Consensus meeting (II): metastatic prostate cancer** — 좌장: **안한종** (울산의대) / **조문기** (원자력병원)
1. Oligo-metastatic prostate cancer: Definition and treatment — **정승일** (전남의대)
2. Chemotherapy in CRPC — **박세훈** (성균관의대 혈액종양내과)
3. CRPC guideline — **박인근** (가천의대 혈액종양내과)
Panel Discussion
증례: 진행 **정승일** (전남의대)
패널: **Isaac Y. Kim, 권기영, 권동득, 민정준, 박세훈, 박인근, 이제련, 이학종, 전성수**

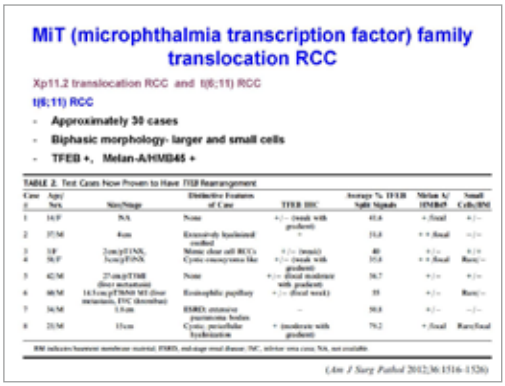
17:10-17:40 **총회**
17:20-17:30 **학술상 시상 및 폐회사 (Adjourn)**

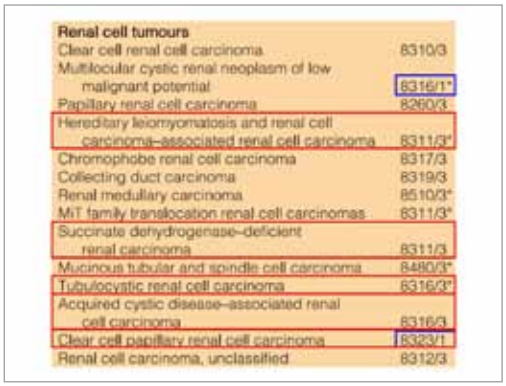

The 14th KUOS Multidisciplinary Conference

문경철

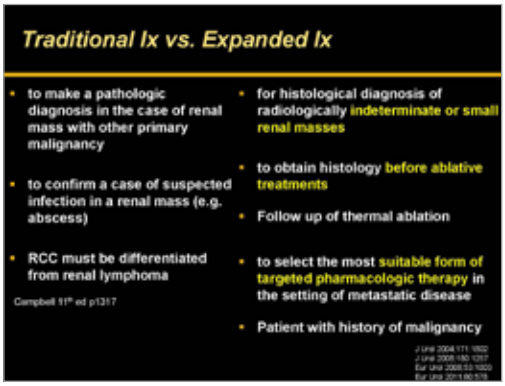

Changed Entities
Collecting duct carcinoma
Carcinoma of collecting duct of Bellini
Rare: less than 1%
Medullary location
Poorer prognosis than other common types

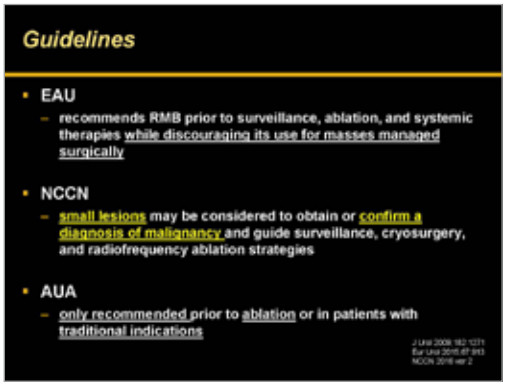

Multilocular cystic renal neoplasm of low malignant potential
(ICD-O 8316/1)
- Multilocular cystic RCC
- Same genetic features to Clear cell RCC
- 3p deletion, VHL mutation
- Very good prognosis
- No expansile carcinoma nodules

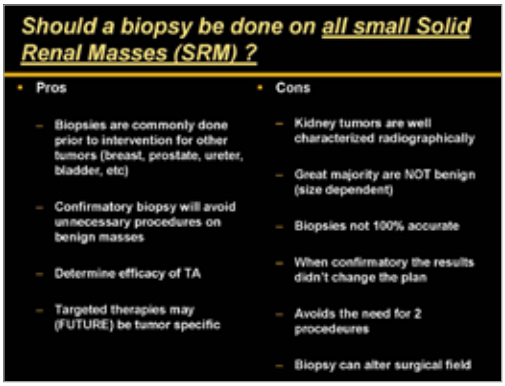

MiT (microphthalmia transcription factor) family translocation RCC
Xp11.2 translocation RCC and t(6;11) RCC
t(6;11) RCC
- Approximately 30 cases
- Biphasic morphology- larger and small cells
- TFEB +, Melan-A/HMB45 +
TABLE 2. Test Cases Now Proven to Have TFEB Rearrangement
(Am J Surg Pathol 2012;36:1316-1326)

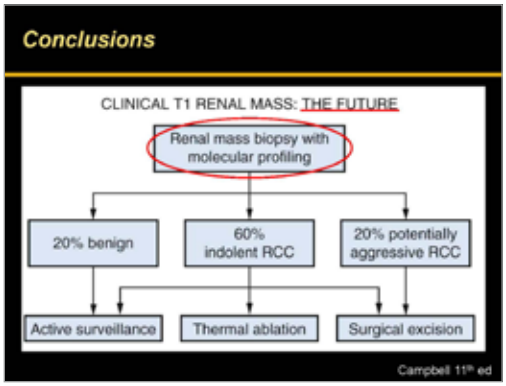

Renal cell tumours
Clear cell renal cell carcinoma 8310/3
Multilocular cystic renal neoplasm of low malignant potential 8316/1*
Papillary renal cell carcinoma 8260/3
Hereditary leiomyomatosis and renal cell carcinoma–associated renal cell carcinoma 8311/3*
Chromophobe renal cell carcinoma 8317/3
Collecting duct carcinoma 8319/3
Renal medullary carcinoma 8510/3*
MiT family translocation renal cell carcinomas 8311/3*
Succinate dehydrogenase–deficient renal carcinoma 8311/3
Mucinous tubular and spindle cell carcinoma 8480/3*
Tubulocystic renal cell carcinoma 8316/3*
Acquired cystic disease–associated renal cell carcinoma 8316/3
Clear cell papillary renal cell carcinoma 8323/1
Renal cell carcinoma, unclassified 8312/3

황의창

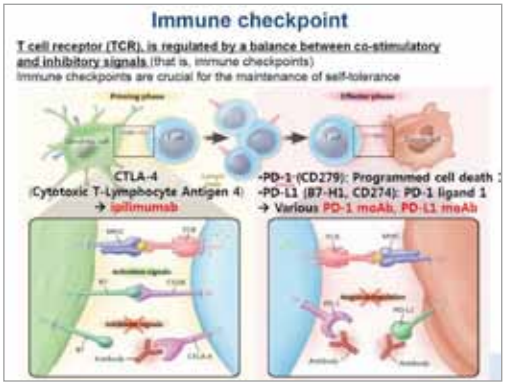

Traditional Ix vs. Expanded Ix
to make a pathologic diagnosis in the case of renal mass with other primary malignancy
to confirm a case of suspected infection in a renal mass (e.g. abscess)
RCC must be differentiated from renal lymphoma
Campbell 11th ed p1317
for histological diagnosis of radiologically indeterminate or small renal masses
to obtain histology before ablative treatments
Follow up of thermal ablation
to select the most suitable form of targeted pharmacologic therapy in the setting of metastatic disease
Patient with history of malignancy

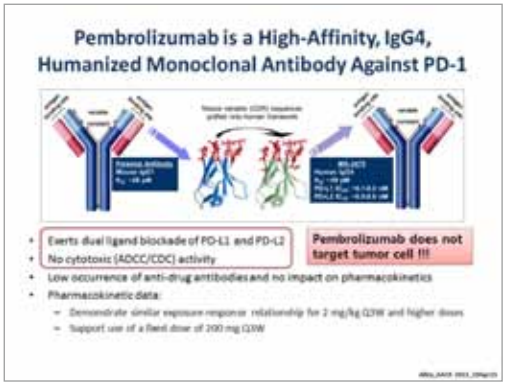

Guidelines
EAU
recommends RMB prior to surveillance, ablation, and systemic therapies while discouraging its use for masses managed surgically
NCCN
small lesions may be considered to obtain or confirm a diagnosis of malignancy and guide surveillance, cryosurgery, and radiofrequency ablation strategies
AUA
only recommended prior to ablation or in patients with traditional indications


Should a biopsy be done on all small Solid Renal Masses (SRM) ?
Pros
Biopsies are commonly done prior to intervention for other tumors (breast, prostate, ureter, bladder, etc)
Confirmatory biopsy will avoid unnecessary procedures on benign masses
Determine efficacy of TA
Targeted therapies may (FUTURE) be tumor specific
Cons
Kidney tumors are well characterized radiographically
Great majority are NOT benign (size dependent)
Biopsies not 100% accurate
When confirmatory the results didn't change the plan
Avoids the need for 2 procedeures
Biopsy can alter surgical field

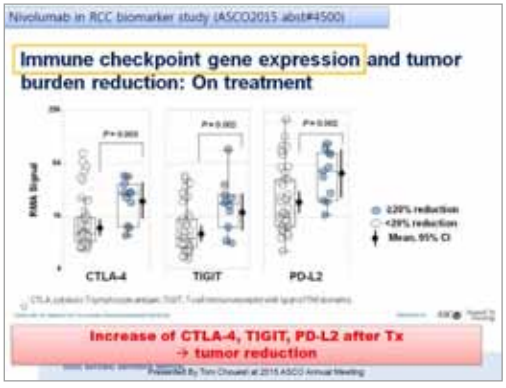

Conclusions
CLINICAL T1 RENAL MASS: THE FUTURE
Renal mass biopsy with molecular profiling
20% benign
60% indolent RCC
20% potentially aggressive RCC
Active surveillance
Thermal ablation
Surgical excision
Campbell 11th ed

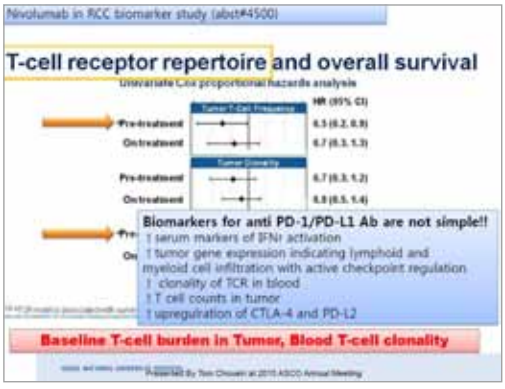
김범석

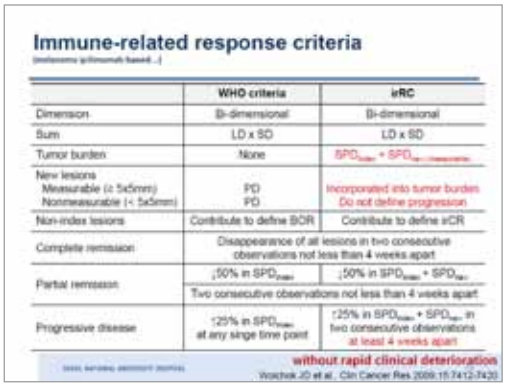

Immune checkpoint
T cell receptor (TCR), is regulated by a balance between co-stimulatory and inhibitory signals (that is, immune checkpoints)
Immune checkpoints are crucial for the maintenance of self-tolerance
CTLA-4
(Cytotoxic T-Lymphocyte Antigen 4)
→ Ipilimumab
-PD-1 (CD279): Programmed cell death
-PD-L1 (B7-H1, CD274): PD-1 ligand 1
→ Various PD-1 mAb, PD-L1 mAb

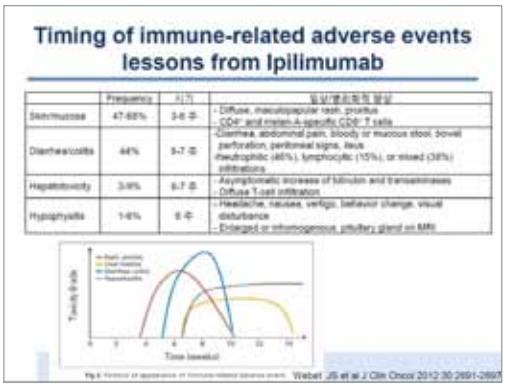

Pembrolizumab is a High-Affinity, IgG4, Humanized Monoclonal Antibody Against PD-1
Exerts dual ligand blockade of PD-L1 and PD-L2
No cytotoxic (ADCC/CDC) activity
Pembrolizumab does not target tumor cell !!!
Low occurrence of anti-drug antibodies and no impact on pharmacokinetics
Pharmacokinetic data:


PD-1/PD-L1 Inhibitors Currently in Clinical Development
Topalian SL et al. Cancer Cell 2015;27:450

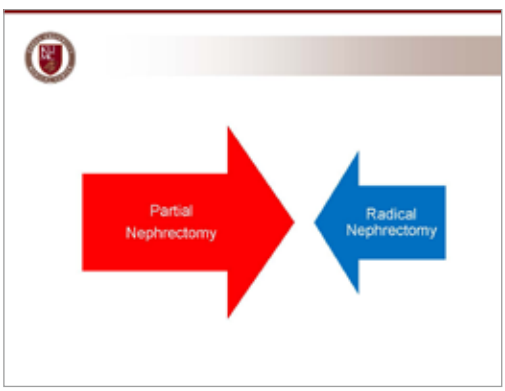

Nivolumab in RCC biomarker study (ASCO2015 abst#4500)
Immune checkpoint gene expression and tumor burden reduction: On treatment
CTLA-4
TIGIT
PD-L2
≥20% reduction
<20% reduction
Mean, 95% CI
Increase of CTLA-4, TIGIT, PD-L2 after Tx
→ tumor reduction

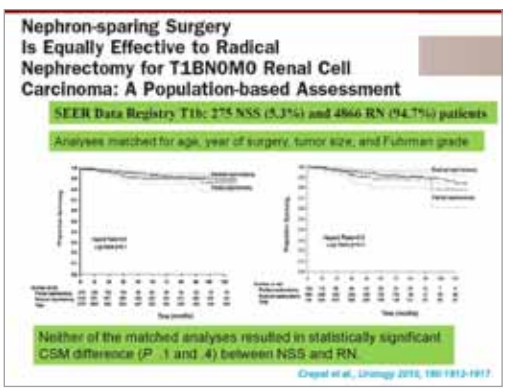

Nivolumab in RCC biomarker study (abst#4500)
T-cell receptor repertoire and overall survival
Univariate Cox proportional hazards analysis
HR (95% CI)
Pre-treatment
On treatment
Biomarkers for anti PD-1/PD-L1 Ab are not simple!!
↑ serum markers of IFNr activation
↑ tumor gene expression indicating lymphoid and myeloid cell infiltration with active checkpoint regulation
↑ clonality of TCR in blood
↑ T cell counts in tumor
↑ upregulation of CTLA-4 and PD-L2
Baseline T-cell burden in Tumor, Blood T-cell clonality

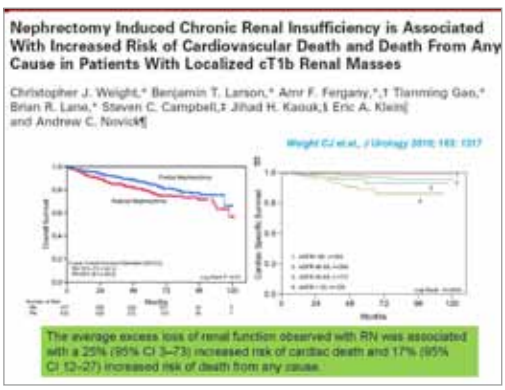

Immune-related response criteria
WHO criteria
irRC
Dimension
Bi-dimensional
Sum
LD x SD
Tumor burden
None
New lesions
Measurable (≥ 5x5mm)
Nonmeasurable (< 5x5mm)
PD
PD
Incorporated into tumor burden
Do not define progression
Non-index lesions
Contribute to define BOR
Contribute to define irCR
Complete remission
Disappearance of all lesions in two consecutive observations not less than 4 weeks apart
Partial remission
↓50% in SPD
↓50% in SPD
Two consecutive observations not less than 4 weeks apart
Progressive disease
↑25% in SPD at any singe time point
↑25% in SPD in two consecutive observations at least 4 weeks apart
without rapid clinical deterioration
Wolchok JD et al. Clin Cancer Res 2009;15:7412-7420

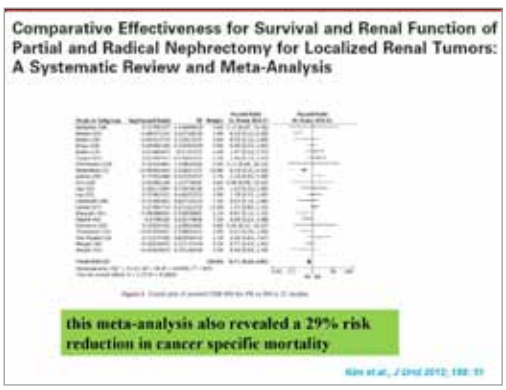

Timing of immune-related adverse events
lessons from Ipilimumab

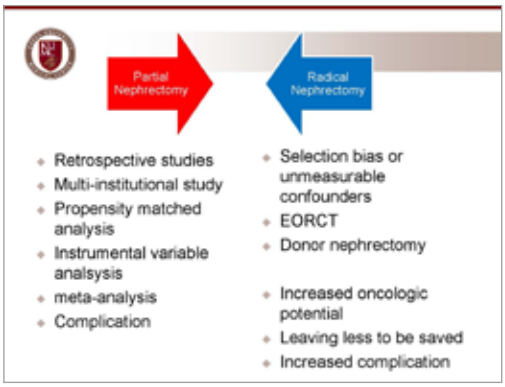
강성구

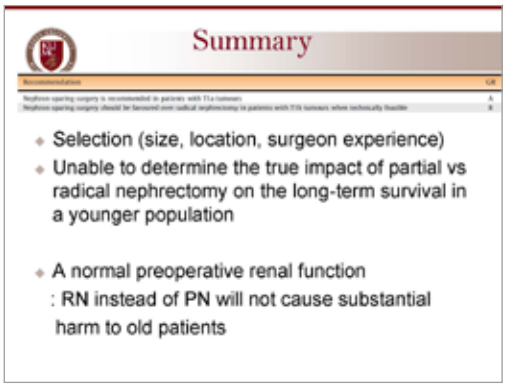

Partial
Nephrectomy
Radical
Nephrectomy


Nephron-sparing Surgery
Is Equally Effective to Radical
Nephrectomy for T1BN0M0 Renal Cell
Carcinoma: A Population-based Assessment
SEER Data Registry T1b: 275 NSS (5.3%) and 4866 RN (94.7%) patients
Analyses matched for age, year of surgery, tumor size, and Fuhrman grade
Neither of the matched analyses resulted in statistically significant
CSM difference (P .1 and .4) between NSS and RN.

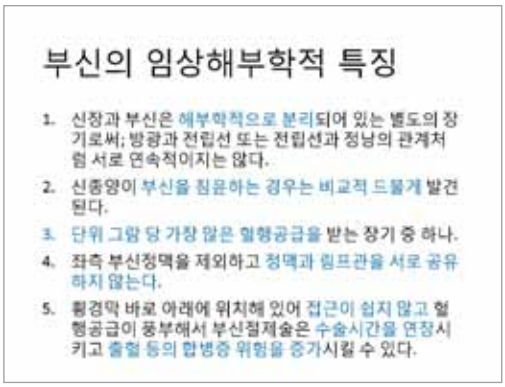

Nephrectomy Induced Chronic Renal Insufficiency is Associated
With Increased Risk of Cardiovascular Death and Death From Any
Cause in Patients With Localized cT1b Renal Masses
The average excess loss of renal function observed with RN was associated
with a 25% (95% CI 3–73) increased risk of cardiac death and 17% (95%
CI 12–27) increased risk of death from any cause.

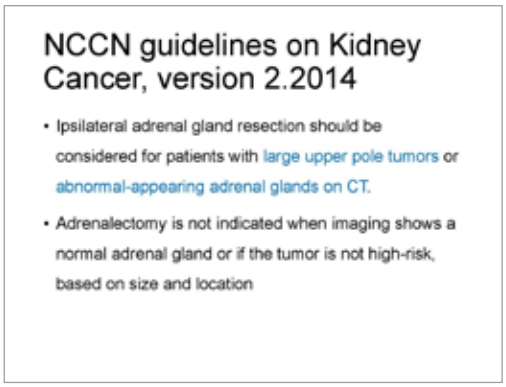

Comparative Effectiveness for Survival and Renal Function of
Partial and Radical Nephrectomy for Localized Renal Tumors:
A Systematic Review and Meta-Analysis
this meta-analysis also revealed a 29% risk
reduction in cancer specific mortality

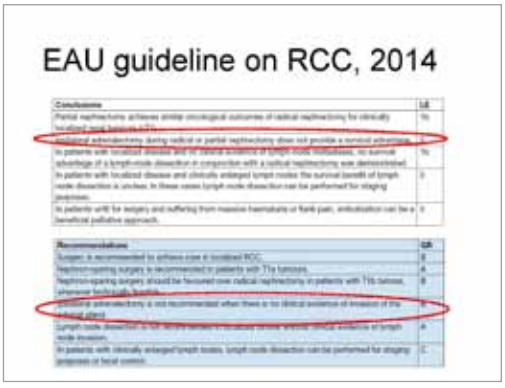

Partial Nephrectomy
Radical Nephrectomy
Retrospective studies
Multi-institutional study
Propensity matched analysis
Instrumental variable analsysis
meta-analysis
Complication
Selection bias or unmeasurable confounders
EORCT
Donor nephrectomy
Increased oncologic potential
Leaving less to be saved
Increased complication

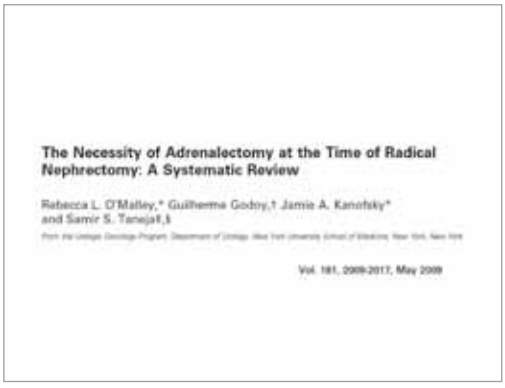

Summary
Selection (size, location, surgeon experience)
Unable to determine the true impact of partial vs radical nephrectomy on the long-term survival in a younger population
A normal preoperative renal function
: RN instead of PN will not cause substantial harm to old patients

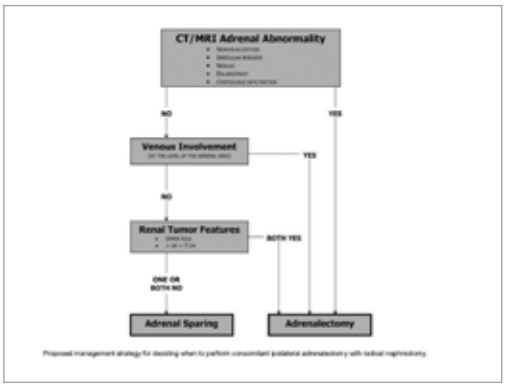
김선일


부신의 임상해부학적 특징
1. 신장과 부신은 해부학적으로 분리되어 있는 별도의 장기로써; 방광과 전립선 또는 전립선과 정낭의 관계처럼 서로 연속적이지는 않다.
2. 신종양이 부신을 침윤하는 경우는 비교적 드물게 발견된다.
3. 단위 그람 당 가장 많은 혈행공급을 받는 장기 중 하나.
4. 좌측 부신정맥을 제외하고 정맥과 림프관을 서로 공유하지 않는다.
5. 횡경막 바로 아래에 위치해 있어 접근이 쉽지 않고 혈행공급이 풍부해서 부신절제술은 수술시간을 연장시키고 출혈 등의 합병증 위험을 증가시킬 수 있다.


NCCN guidelines on Kidney Cancer, version 2.2014
• Ipsilateral adrenal gland resection should be considered for patients with large upper pole tumors or abnormal-appearing adrenal glands on CT.
• Adrenalectomy is not indicated when imaging shows a normal adrenal gland or if the tumor is not high-risk, based on size and location


EAU guideline on RCC, 2014

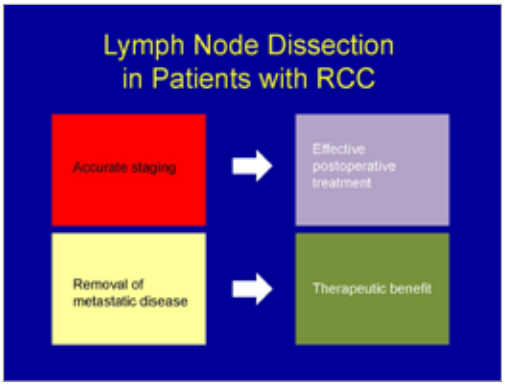

The Necessity of Adrenalectomy at the Time of Radical Nephrectomy: A Systematic Review
Rebecca L. O'Malley,* Guilherme Godoy,† Jamie A. Kanofsky* and Samir S. Taneja†,‡
Vol. 181, 2009-2017, May 2009

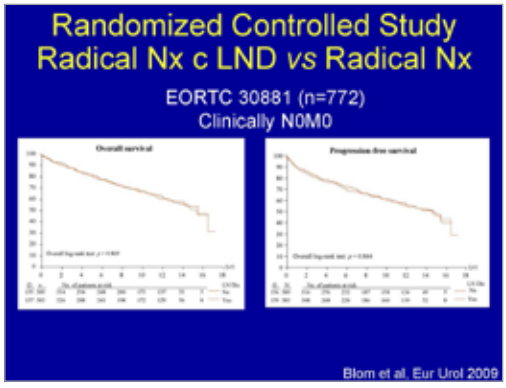


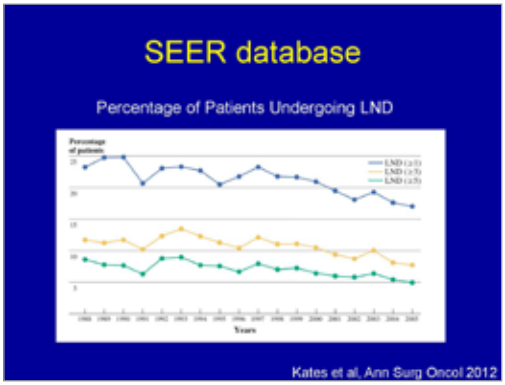
결론

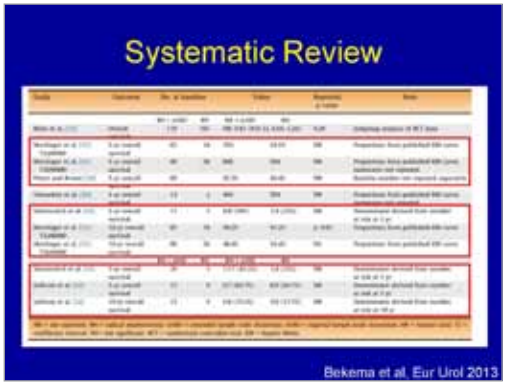
- 근치적 신절제술시 동측 부신절제술은 일상적으로 시행하지 않는다.
- 부신 침윤에 대한 CT 등 영상의학검사의 민감도와 음성예측률이 높기 때문에 CT 판독에 이상소견이 있을 경우에 한정해서 부신절제술을 시행한다.
- 단, 부신 근처의 큰 종양이나 좌측 신정맥내 종양혈전이 있는 좌측신암, 대정맥내 종양혈전이 있는 우측신암은 부신절제술을 시행하는 것이 좋다.
- 부분신절제술의 경우에도 근치적 신절제술과 같은 원칙으로 부신절제 여부를 결정한다.

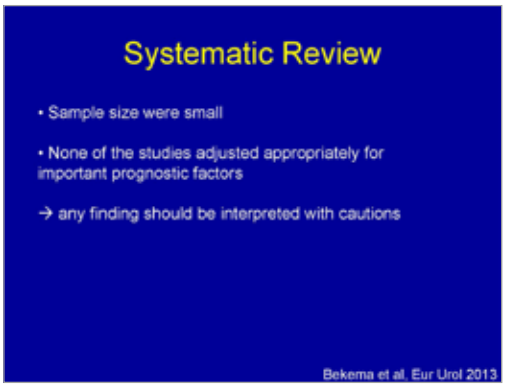
이동현

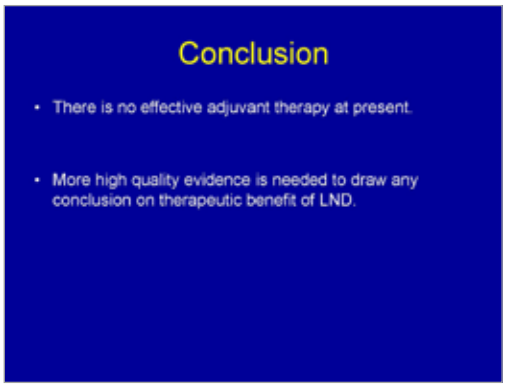




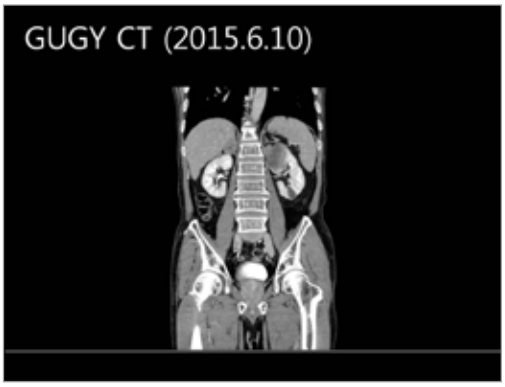


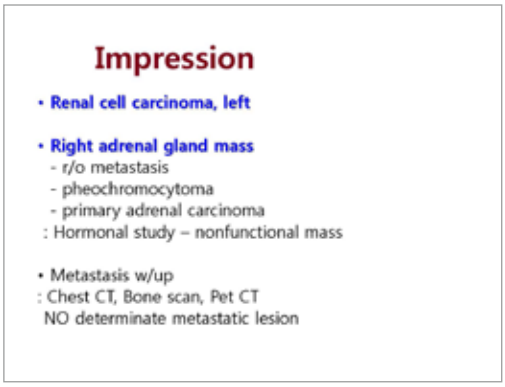


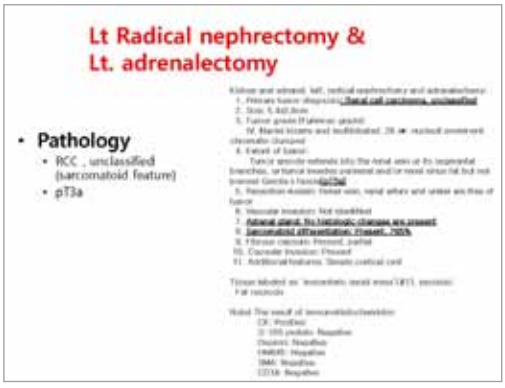

Systematic Review
• Sample size were small
• None of the studies adjusted appropriately for important prognostic factors
→ any finding should be interpreted with cautions
Bekema et al. Eur Urol 2013

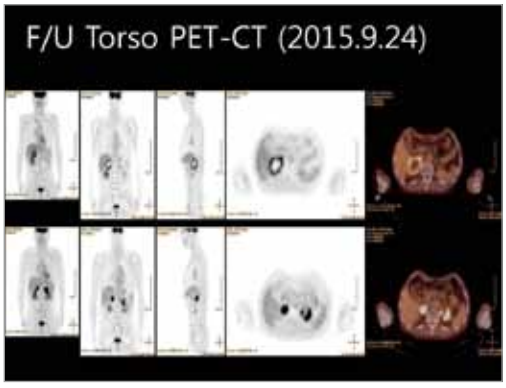

Conclusion
• There is no effective adjuvant therapy at present.
• More high quality evidence is needed to draw any conclusion on therapeutic benefit of LND.

강성구


GUGY CT (2015.6.10)


Impression
• Renal cell carcinoma, left
• Right adrenal gland mass
- r/o metastasis
- pheochromocytoma
- primary adrenal carcinoma
: Hormonal study – nonfunctional mass
• Metastasis w/up
: Chest CT, Bone scan, Pet CT
NO determinate metastatic lesion

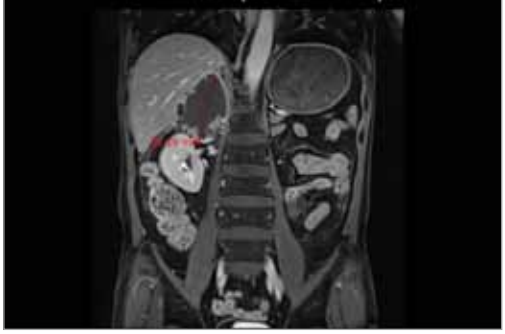

Lt Radical nephrectomy &
Lt. adrenalectomy
• Pathology
• RCC , unclassified (sarcomatoid feature)
• pT3a


F/U Torso PET-CT (2015.9.24)

Target therapy

- 1L1C CTx. (Torisel(Temsirolimus) mono)
  - 8th wks. (2015.10.13 ~ 2015.12.2)
- HO admission (2015.12.3) – f/u evaluation

MRI Abdomen (2015.12.4)



- **RCC with sarcomatoid feature (Fuhrman grade 4)**
  c multiple lung metastases
  c rt. adrenal gland & liver & rt. kidney & IVC
  c ascending colon

s/p Lt. radical nephrectomy with adrenalectomy

What is your next plan?

Pulmonary Tb

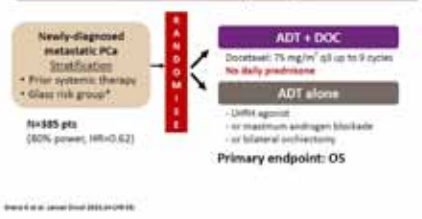
- General weakness & fever (38.3 ℃)
- Sputum collection
  - AFB Fluorescent Stain (+)
  - AFB culture: Mycobacterium tuberculosis complex (+)
- Tb medication start (2015.12.3)
  - Isoniazid
  - Rifampicin
  - Pyrazinamide
  - Ethambutol
  - Pyridoxine

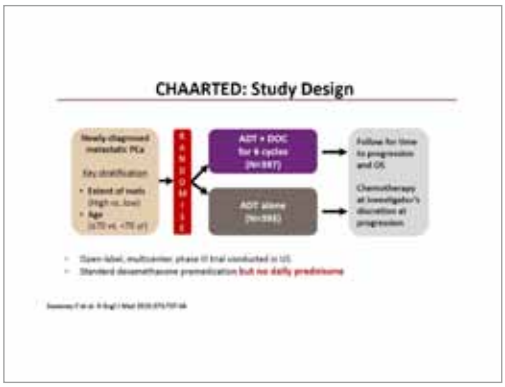
Noep Clarke

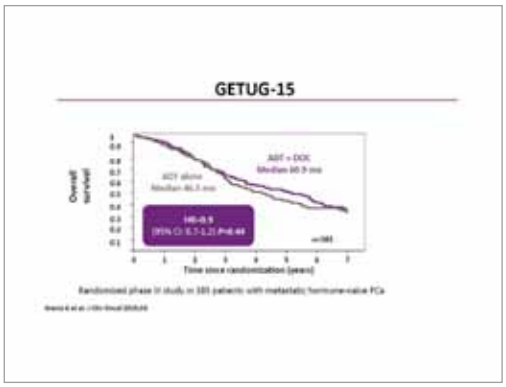
Initial Chemotherapy in Hormone Sensitive Prostate Cancer

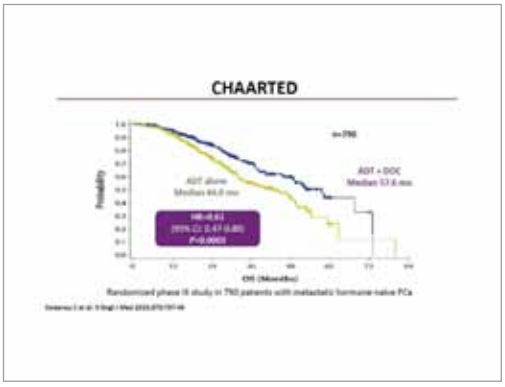
NW Clarke
Consultant Urological Surgeon
Professor of Urological Oncology
Manchester, UK

GETUG-15: Study Design

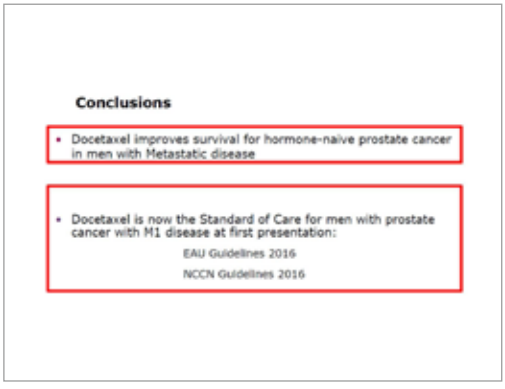



CHAARTED: Study Design
Newly diagnosed metastatic PCa
Key stratification
Extent of mets (High vs. Low)
Age (≥70 vs. <70 yr)
RANDOMIZE
ADT + DOC for 6 cycles (N=397)
ADT alone (N=391)
Follow for time to progression and OS
Chemotherapy at investigator's discretion at progression
Open-label, multicenter, phase III trial conducted in US
Standard dexamethasone premedication but no daily prednisone

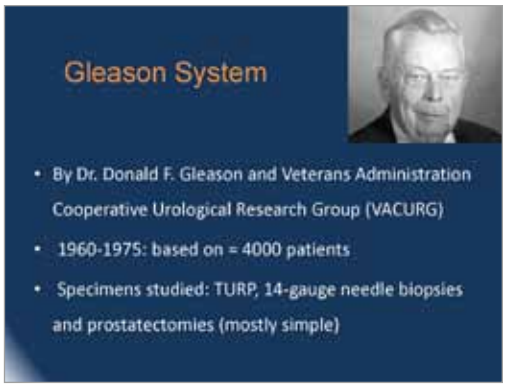

GETUG-15
Overall survival
ADT + DOC
Median 66.9 mo
ADT alone
Median 46.3 mo
HR=0.9
(95% CI: 0.7-1.2) P=0.44
n=385
Time since randomization (years)
Randomized phase III study in 385 patients with metastatic hormone-naive PCa

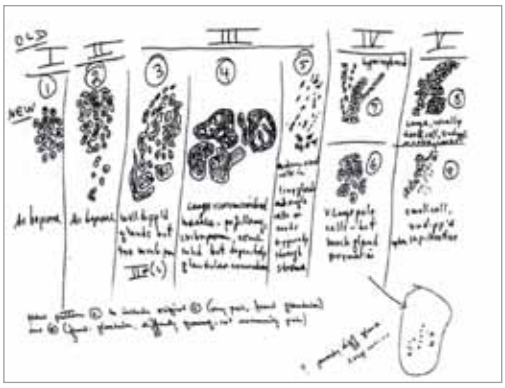

CHAARTED
n=790
Probability
ADT + DOC
Median 57.6 mo
ADT alone
Median 44.0 mo
HR=0.61
(95% CI: 0.47-0.80)
P=0.0003
OS (Months)
Randomized phase III study in 790 patients with metastatic hormone-naive PCa

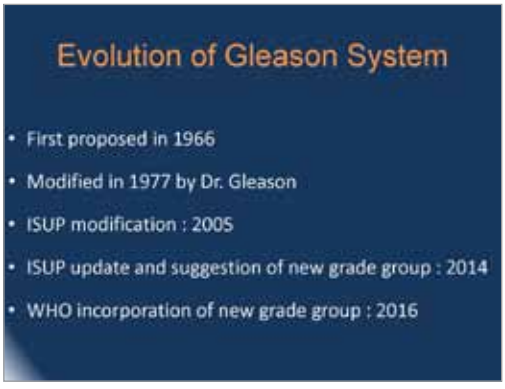

Addition of docetaxel, zoledronic acid, or both to first-line long-term hormone therapy in prostate cancer (STAMPEDE): survival results from an adaptive, multiarm, multistage, platform randomised controlled trial

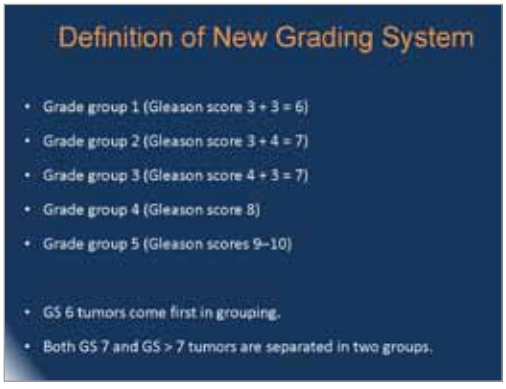

Conclusions
Docetaxel improves survival for hormone-naive prostate cancer in men with Metastatic disease
Docetaxel is now the Standard of Care for men with prostate cancer with M1 disease at first presentation:
EAU Guidelines 2016
NCCN Guidelines 2016

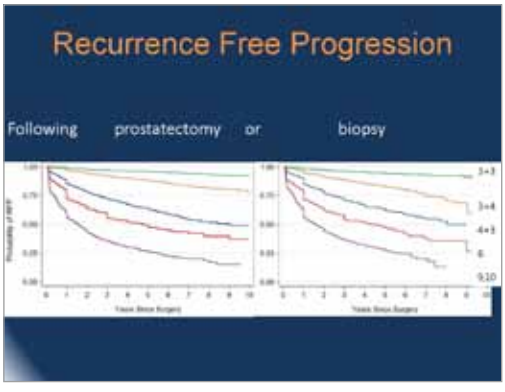
권기영


Gleason System
• By Dr. Donald F. Gleason and Veterans Administration Cooperative Urological Research Group (VACURG)
• 1960-1975: based on = 4000 patients
• Specimens studied: TURP, 14-gauge needle biopsies and prostatectomies (mostly simple)



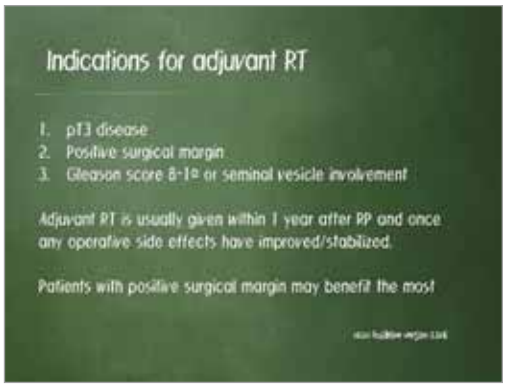

Evolution of Gleason System
• First proposed in 1966
• Modified in 1977 by Dr. Gleason
• ISUP modification : 2005
• ISUP update and suggestion of new grade group : 2014
• WHO incorporation of new grade group : 2016

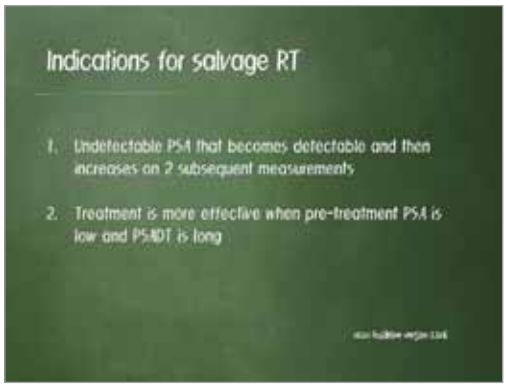

Definition of New Grading System
• Grade group 1 (Gleason score 3 + 3 = 6)
• Grade group 2 (Gleason score 3 + 4 = 7)
• Grade group 3 (Gleason score 4 + 3 = 7)
• Grade group 4 (Gleason score 8)
• Grade group 5 (Gleason scores 9–10)
• GS 6 tumors come first in grouping.
• Both GS 7 and GS > 7 tumors are separated in two groups.

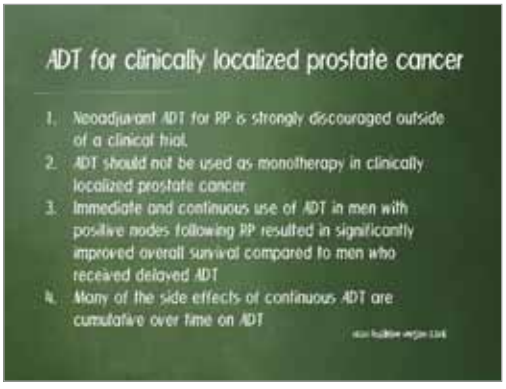

Recurrence Free Progression
Following prostatectomy or biopsy


Advantages of new Grading System
• More accurate grade stratification
• (Simplified grading)
• Lowest grade in practice is designated as grade 1.
– Avoids potential misunderstanding from the patients.

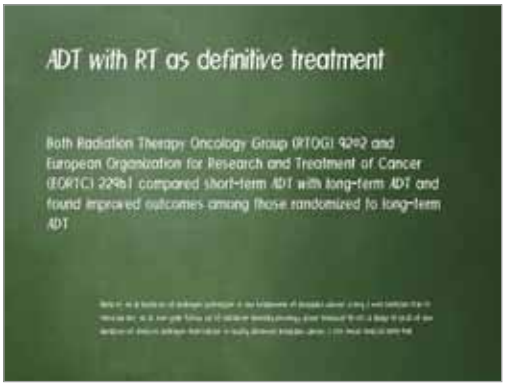
김태환

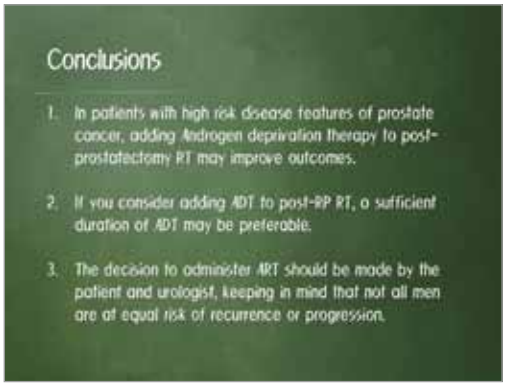

Indications for adjuvant RT
1. pT3 disease
2. Positive surgical margin
3. Gleason score 8-10 or seminal vesicle involvement
Adjuvant RT is usually given within 1 year after RP and once any operative side effects have improved/stabilized.
Patients with positive surgical margin may benefit the most


Indications for salvage RT
1. Undetectable PSA that becomes detectable and then increases on 2 subsequent measurements
2. Treatment is more effective when pre-treatment PSA is low and PSADT is long

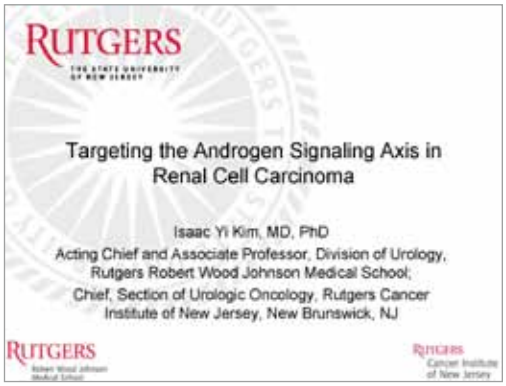

ADT for clinically localized prostate cancer
1. Neoadjuvant ADT for RP is strongly discouraged outside of a clinical trial.
2. ADT should not be used as monotherapy in clinically localized prostate cancer
3. Immediate and continuous use of ADT in men with positive nodes following RP resulted in significantly improved overall survival compared to men who received delayed ADT
4. Many of the side effects of continuous ADT are cumulative over time on ADT

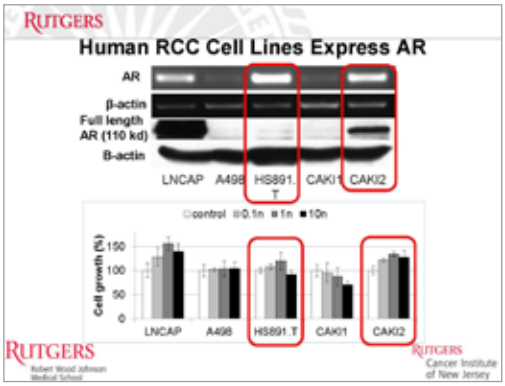

ADT with RT as definitive treatment
The addition of androgen deprivation therapy (ADT) to external-beam radiation therapy (EBRT) as definitive treatment for high-risk localized prostate cancer (PCa) has been demonstrated to improve patient outcomes in multiple randomized controlled trials.
An advantage in overall survival (OS) has been associated with both the use of short-term ADT (4-6 months) and long-term ADT (2-3 years) for men treated with definitive radiation therapy (RT).

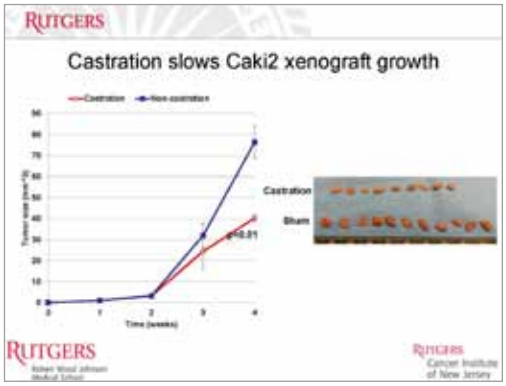

ADT with RT as definitive treatment
Both Radiation Therapy Oncology Group (RTOG) 9202 and European Organization for Research and Treatment of Cancer (EORTC) 22961 compared short-term ADT with long-term ADT and found improved outcomes among those randomized to long-term ADT

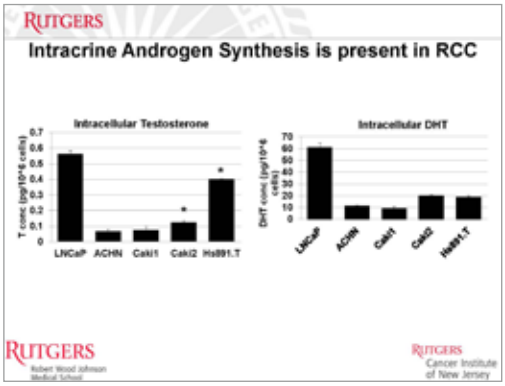

Conclusions
1. In patients with high risk disease features of prostate cancer, adding Androgen deprivation therapy to post-prostatectomy RT may improve outcomes.
2. If you consider adding ADT to post-RP RT, a sufficient duration of ADT may be preferable.
3. The decision to administer ART should be made by the patient and urologist, keeping in mind that not all men are at equal risk of recurrence or progression.

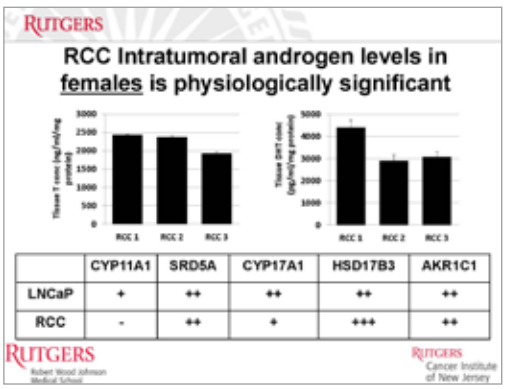
Isaac Y, Kim



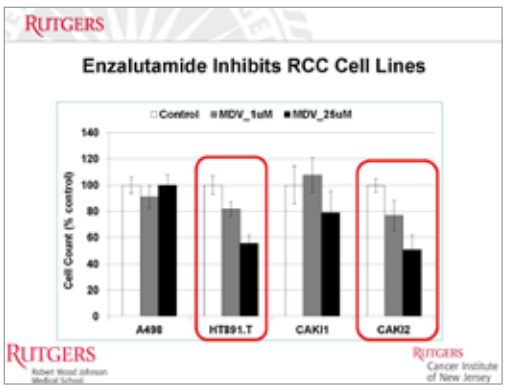


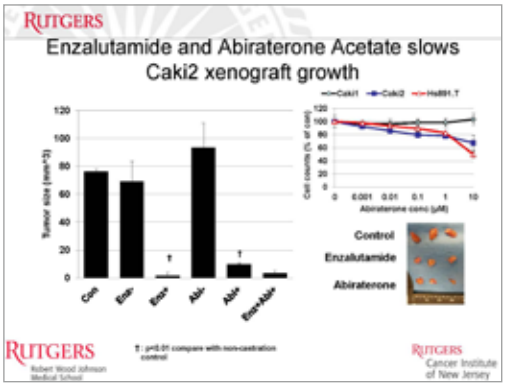


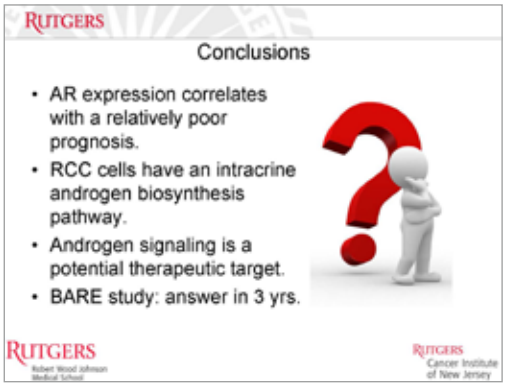




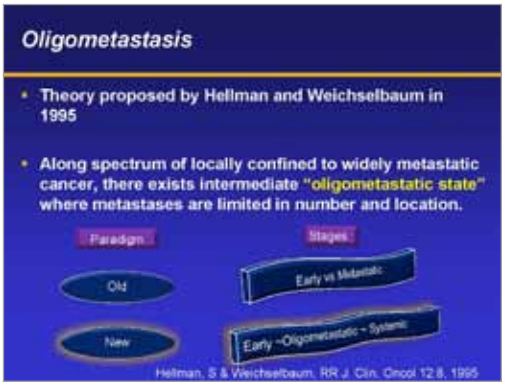
	CYP11A1	SRD5A	CYP17A1	HSD17B3	AKR1C1
LNCaP	+	++	++	++	++
RCC	-	++	+	+++	++

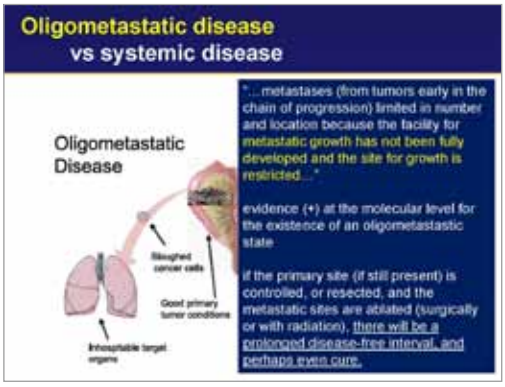


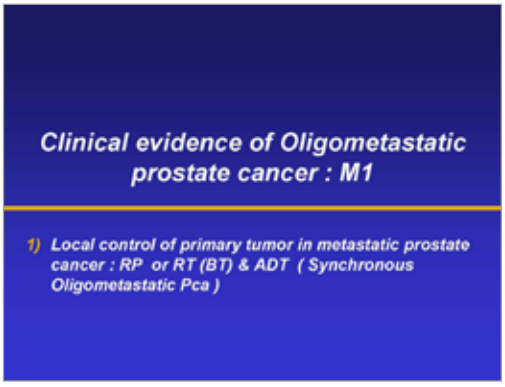

RUTGERS
Enzalutamide and Abiraterone Acetate slows Caki2 xenograft growth
Control
Enzalutamide
Abiraterone
RUTGERS
Cancer Institute of New Jersey

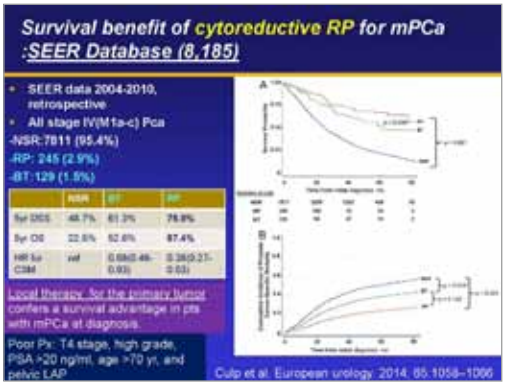

RUTGERS
Conclusions
• AR expression correlates with a relatively poor prognosis.
• RCC cells have an intracrine androgen biosynthesis pathway.
• Androgen signaling is a potential therapeutic target.
• BARE study: answer in 3 yrs.
RUTGERS
Cancer Institute of New Jersey

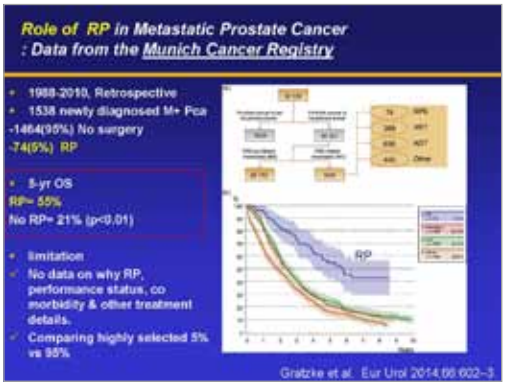
정승일

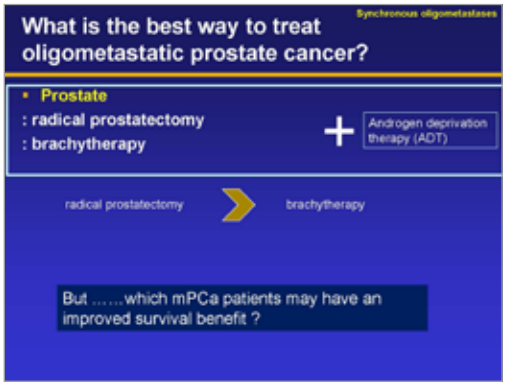

Oligometastasis
• Theory proposed by Hellman and Weichselbaum in 1995
• Along spectrum of locally confined to widely metastatic cancer, there exists intermediate "oligometastatic state" where metastases are limited in number and location.
Paradigm
Stages
Old
New
Early vs Metastatic
Early →Oligometastatic→ Systemic
Hellman, S & Weichselbaum, RR J Clin Oncol 12:8, 1995

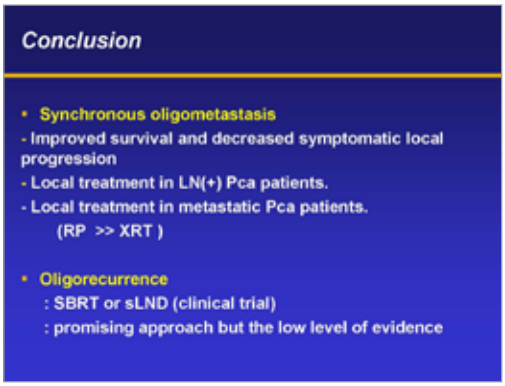

Oligometastatic disease
vs systemic disease
Oligometastatic Disease
"... metastases (from tumors early in the chain of progression) limited in number and location because the facility for metastatic growth has not been fully developed and the site for growth is restricted..."
evidence (+) at the molecular level for the existence of an oligometastastic state
if the primary site (if still present) is controlled, or resected, and the metastatic sites are ablated (surgically or with radiation), there will be a prolonged disease-free interval, and perhaps even cure.

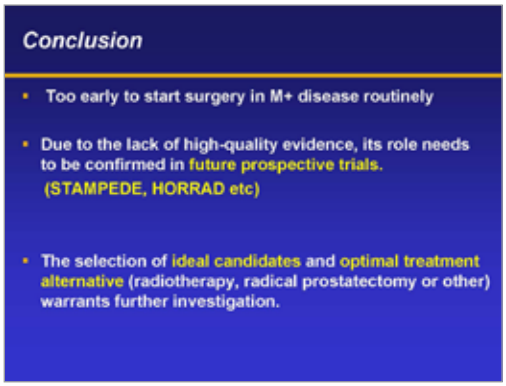

Clinical evidence of Oligometastatic prostate cancer : M1
1) Local control of primary tumor in metastatic prostate cancer : RP or RT (BT) & ADT (Synchronous Oligometastatic Pca)


Survival benefit of cytoreductive RP for mPCa :SEER Database (8,185)
• SEER data 2004-2010, retrospective
• All stage IV(M1a-c) Pca
-NSR:7811 (95.4%)
-RP: 245 (2.9%)
-BT:129 (1.5%)
Local therapy for the primary tumor confers a survival advantage in pts with mPCa at diagnosis
Poor Px: T4 stage, high grade, PSA >20 ng/ml, age >70 yr, and pelvic LAP
Culp et al. European urology. 2014; 65:1058–1066

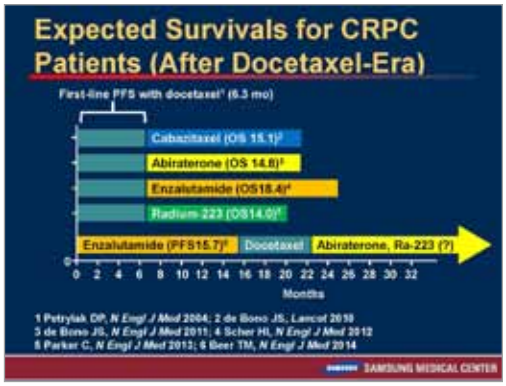

Role of RP in Metastatic Prostate Cancer
: Data from the Munich Cancer Registry
1988-2010, Retrospective
1538 newly diagnosed M+ Pca
-1464(95%) No surgery
-74(6%) RP
5-yr OS
RP= 55%
No RP= 21% (p<0.01)
limitation
No data on why RP, performance status, co morbidity & other treatment details.
Comparing highly selected 5% vs 95%
RP
Gratzke et al. Eur Urol 2014;66:602–3


Synchronous oligometastases
What is the best way to treat oligometastatic prostate cancer?
Prostate
: radical prostatectomy
: brachytherapy
Androgen deprivation therapy (ADT)
radical prostatectomy
brachytherapy
But .....which mPCa patients may have an improved survival benefit ?


Conclusion
Synchronous oligometastasis
- Improved survival and decreased symptomatic local progression
- Local treatment in LN(+) Pca patients.
- Local treatment in metastatic Pca patients.
(RP >> XRT)
Oligorecurrence
: SBRT or sLND (clinical trial)
: promising approach but the low level of evidence


Conclusion
Too early to start surgery in M+ disease routinely
Due to the lack of high-quality evidence, its role needs to be confirmed in future prospective trials.
(STAMPEDE, HORRAD etc)
The selection of ideal candidates and optimal treatment alternative (radiotherapy, radical prostatectomy or other) warrants further investigation.

박세훈


Expected Survivals for CRPC Patients (After Docetaxel-Era)
First-line PFS with docetaxel[1] (6.3 mo)
Cabazitaxel (OS 15.1)[2]
Abiraterone (OS 14.8)[3]
Enzalutamide (OS18.4)[4]
Radium-223 (OS14.0)[5]
Enzalutamide (PFS15.7)[4]
Docetaxel
Abiraterone, Ra-223 (?)
0 2 4 6 8 10 12 14 16 18 20 22 24 26 28 30 32
Months
1 Petrylak DP, N Engl J Med 2004; 2 de Bono JS, Lancet 2010
3 de Bono JS, N Engl J Med 2011; 4 Scher HI, N Engl J Med 2012
5 Parker C, N Engl J Med 2013; 6 Beer TM, N Engl J Med 2014
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Issues Considered When We Choose Treatment Options
Cabazitaxel (Jevtana®)
Radium-223 (Xofigo®)
Docetaxel (Taxotere®)
Abiraterone (Zytiga®)
Enzaluta-mide (Xtandi®)
Sipuleucel-T (Provenge®)
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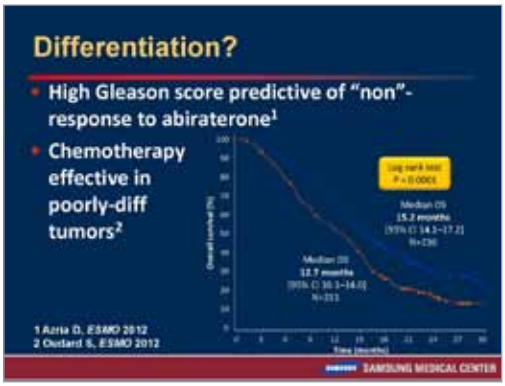

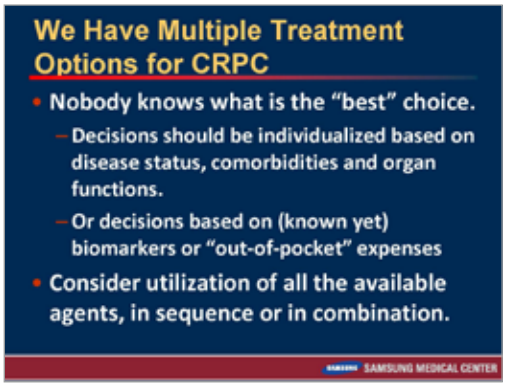

박인근

[KQ2.1.] 거세저항성 상태의 진단 기준 및 확인 방법은 무엇인가?

- 거세 저항성 전립선암으로 진단하기 위해서는 **호르몬 박탈 치료 유지 중, 테스토스테론 혈중 수치가 거세 수준**이어야 하고, **혈중 PSA 수치가 최소한 1주 간격으로 3회 측정한 검사에서 2회 이상 상승**하거나, 신체검진, 방사선학적 검사, 또는 골격 핵의학 검사에서 **악화 소견**이 확인되어야 한다 (LE: 5; GR: SR).

[KQ2.2.] 거세저항성 전립선암 환자에서 남성호르몬 박탈치료는 지속되어야 하는가?

- 거세 저항성 전립선암으로 진행된 환자라도 추가적인 치료와 상관없이 내·외과적 **호르몬 박탈 치료는 지속**되어야 한다 (LE: 1a-1c; GR: SR).

[KQ2.3.] 전립선 신경내분비암은 어떤 경우 의심하고 진단하여야 하는가?

- 거세저항성 전립선암 치료 중 혈중 **PSA수치의 변화는 크지 않으나** 임상적, 영상의학적, 또는 핵의학적 검사에서는 **빠르게 진행하는 경우**에 신경내분비암이 아닌지 확인하여야 한다 (LE: 4; GR: SR).

[KQ2.4.] 전이성 전립선암에서 어떤 치료를 결정하기 전 고려되어야 할 사항은 무엇이며 치료의 목표 설정은 어떻게 하는가?

- 치료를 결정하기 전에 환자에게 **치료의 효과와 부작용 및 비용에 대한 정보를 제공**해야 하며, 환자가 치료의 목적을 이해할 수 있도록 해야 한다 (LE: 5; GR: SR).
- 환자의 **동반된 질환을 평가**해야 하며, 만성 질환이 2가지 이상인 경우 치료의 복합성과 불확실성을 고려하여 개인의 상태에 맞는 치료계획을 세우고, **공동의사결정(shared decision making)**을 하도록 한다 (LR: 5; GR: SR).
- **완화적 돌봄(palliative care)**은 모든 환자에게 제공되어야 하며, 증상이 있거나 삶의 질이 저하된 환자에게 치료의 종류에 상관없이 제공해야 한다 (LE: 5; GR: SR).

[KQ2.5.] 도세탁셀 항암치료를 받지 않은 거세저항성 전립선암에서 아비라테론 또는 엔잘루타마이드는 효과적인 치료법인가?

- 도세탁셀 치료 경험이 없는 **무증상 또는 경미한 증상**을 가진 거세저항성 전립선암에서 **아비라테론과 프레드니손 병용요법 또는 엔잘루타마이드 요법은 일차치료로 고려**되어야 한다 (LE: 1a; GR: WR).

[KQ2.6.] 거세저항성 전립선암의 치료에 있어 도세탁셀 항암치료의 임상적 의의는 무엇인가?

- **도세탁셀과 (3주 간격 또는 2주 간격) 프레드니솔론의 병용요법**은 전이성 거세저항성 전립선 암환자의 **1차 항암치료의 표준요법**이다 (LE: 1a; GR: SR).
- 에스트라무스틴과의 병합치료도 1차 항암치료로 고려해 볼 수 있다 (LE: 1b; GR: WR).

[KQ2.7.] 도세탁셀 항암치료 후 진행하는 거세저항성 전립선암에서 아비라테론 또는 엔잘루타마이드는 효과적인 치료법인가?

- 이전 **아비라테론이나 엔잘루타마이드치료 병력이 없는** 거세저항성 전립선암 환자가 **도세탁셀 치료 이후 진행된 경우 아비라테론과 프레드니손 요법 또는 엔잘루타마이드 요법을 고려**하여야 한다 (LE: 1b; GR: SR).

[KQ2.8.] 도세탁셀 항암치료 후 진행하는 거세저항성 전립선암에서 카바지탁셀은 효과적인 치료법인가?

- **카바지탁셀**은 프레드니솔론과 병용하여 이전에 **도세탁셀을 포함한 화학요법 치료를 받은 적이 있는** 호르몬 저항성 전이성 전립선암의 치료로 고려되어야 한다. (LE:1b; GR: SR)

[KQ2.9.] 거세저항성 전립선암에서 미토잔트론의 효과는?

- **미토잔트론**과 당질코르티코이드 병합치료는 거세 저항성 전이성 전립선암에서 **생존 기간을 연장시켜주지는 못하지만** 도세탁셀이나 카바지탁셀을 사용할 수 없는 경우, **증상 호전을 목적으로 사용**할 수 있다 (LE: 1b; GR: WR).

[KQ2.10.] 거세저항성 전립선암에서 케토코나졸, 에스트라무스틴 또는 비카루타마이드의 효과는?

- **케토코나졸과 코르티코스테로이드 병용요법**은 거세저항성 전이성 전립선암의 2차 호르몬 치료로 사용 시 객관적 반응율과 PSA반응율의 효과를 보일 수 있으나 **생존기간의 개선은 보여주지 못하였다.** (LE: 2b; GR: WR).
- 거세저항성 전립선암의 치료에 있어 에스트라무스틴 및 비카루타미드 등과 같은 **불특정 2차 호르몬 치료제**들은 단기간 PSA감소 등과 같은 효과를 가져올 수 있지만, **생존기간을 증가시킨다는 근거는 없다.** (LE: 2c; GR: WR)

[KQ2.11.] 졸레드로네이트 또는 데노수맵을 거세저항성 전립선암 환자에게 사용해야 하는가?

- **골 관련 합병증의 위험성이 높은 다발성 골전이를 동반한** 거세 불응성 전립선 암환자에게 **데노수맵 또는 졸레드로네이트 등 뼈를 표적으로 하는 약제들을 사용**하여야 한다. 데노수맵 혹은 졸레드레네이트 등의 약제를 사용하기 전 **치과 검사를 시행**하여야 하며, 치료 시 경구 칼슘 및 비타민 D제제를 같이 사용하고 주기적으로 혈청 칼슘 농도를 측정하는 것이 권고된다 (LE: 1a; GR: SR).

[KQ2.12.] 골격전이를 동반한 거세저항성 전립선암 환자에서 Radium-223치료는 효과적인가?

- **Radium-223**은 **내장 장기 전이를 동반하지 않고 증상이 있는 골전이를 동반**한 거세 저항성 전립선암 환자에게 사용시 통증을 완화하고 골관련 합병증을 줄이며 생존기간을 연장시킨다 (LE: 1a; GR: WR).

[KQ2.13.] 거세저항성 전립선암에서 치료에 대한 반응 판정은 어떻게 하는가?

- 거세저항성 전립선암 환자에서 반응판정은 전산화 단층촬영이나 자기공명영상과 같은 **영상의학적 방법** (골전이를 제외한 연부조직 전이 및 내장전이), 골주사 검사와 같은 **핵의학적 방법** (골전이), 혈중 **전립선 특이항원농도**, 그리고 **증상**을 고려하여 **종합적으로 판단**한다 (LE: 5; GR: SR).

학회소식

차기회장:

한림대 조진선교수가 이사회에서 차기회장으로 추대되었다.

임기는 2016년 9월부터 2년간이다.

학술상

- 임상: 남종길, 정문기: Predicting progression and survival in Korean patients with high grade T1 bladder cancer using EORTC risk tables
- 기초: 임송원, 지병훈: The internalization of BCG in bladder cancer cells may be inhibited by human beta-defensin 3

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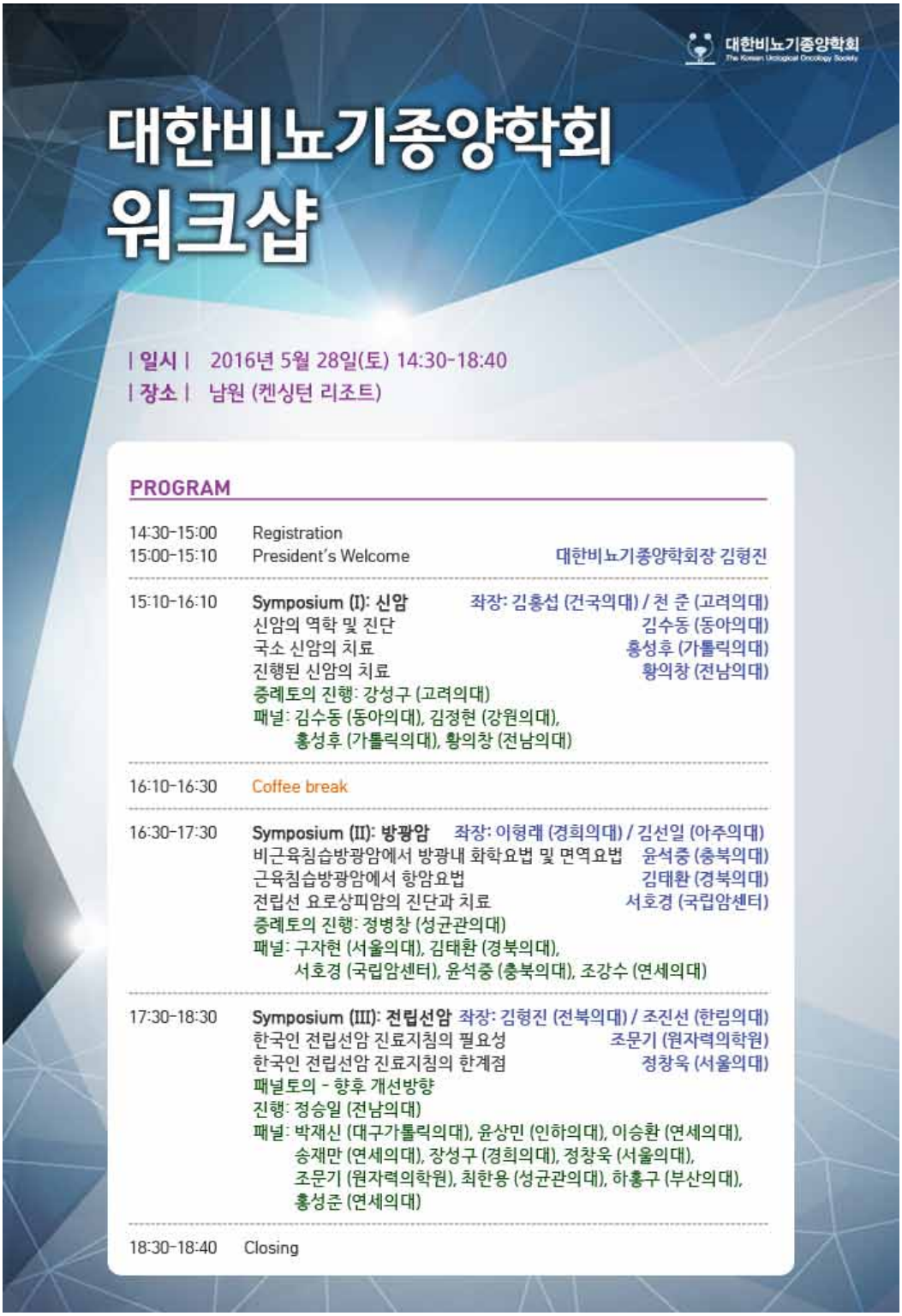


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