Panel Discussion

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Case 1
- 24 y/o male with h/o spina bifida and neurogenic colon/bladder. He has a urinary diversion (catheterizable stoma) and is s/p ACE (antegrade continent enema procedure) when he was 15.
- Pt is also s/p previous L simple nephrectomy for a nonfunctioning L kidney with a staghorn stone

- Now presents with frequent UTI’s, where he manifests in fevers, nausea/vomiting.
- Patient performs self catheterization ~Q2 hours with irrigation at least once a day
How would you approach this surgically?
Case 2

- 76 y/o male with multiple medical problems: MI, cardiomyopathy, PVD, COPD, obesity presented to primary urologist with painless total gross hematuria.
- w/u included cystoscopy- normal, urine cytology- normal
- Initial CT showed 2.2cm filling defect in R renal pelvis
Pt taken to O R- Intraop a large papillary tumor was seen in the R renal pelvis. Biopsy was taken-path was inconclusive. Selective urine cytology was also inconclusive atypical cells
CT was repeated when pt was sent to LAMC
Patient underwent repeat R URS that showed a large papillary tumor in R renal pelvis >2cm

- Biopsy path showed papillary urothelial carcinoma of low malignant potential
What would you do next?

- Pt was cleared medically
- Underwent R PCN resection of tumor with 26F resectoscope
- Stent left in for 4 weeks
- Path showed papillary urothelial carcinoma of low malignant potential. Muscularis propria present without invasion
- How would you follow?
Case 3

- 60-year old woman with complaints of intermittent left flank pain, dysuria and repeatedly positive urine cultures for Proteus Mirabilis for approximately one year. Symptoms usually resolve after each course of abx, but would recur frequently
- Pmed Hx: HTN; No hx of renal stones
What would you do next?

- Due to its size (2.2cm) and the appearance on CT that its infundibular extension was within a major calyx we proceeded with left percutaneous nephrolithotomy
L retrograde pyelogram was performed, revealing a collecting system without any obvious image of the diverticulum.

PCN access was placed into the lower pole in an attempt to access the stone from the infundibular portion into the diverticulum. Percutaneous nephroscopy was performed in a systematic fashion using rigid and flexible nephroscope.

Unable to visualize the stone

Presumably because the infundibular extension of the stone was not in the major calyx. We then aborted the procedure, and left a ureteral stent in place.

What would you do next?
Due to the anterior location of the stone, we took her back to the operating room for laparoscopic unroofing/partial nephrectomy and stone extraction six weeks later.
End