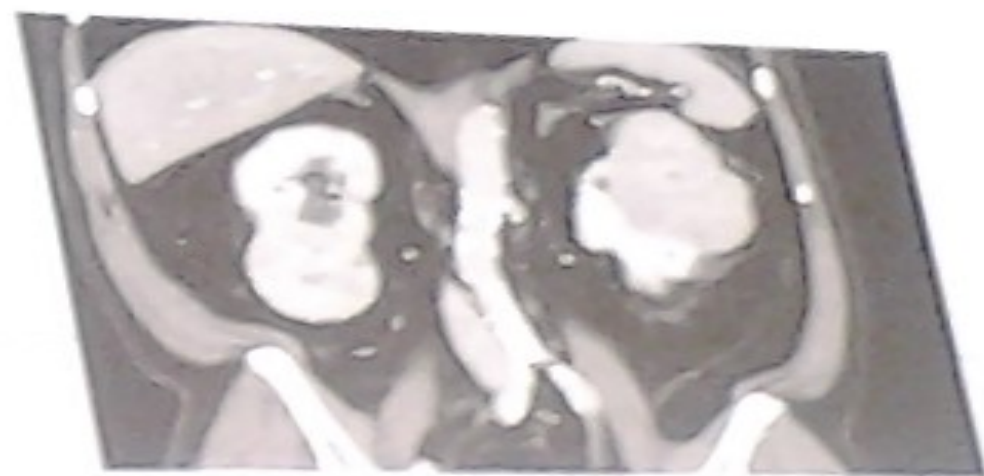
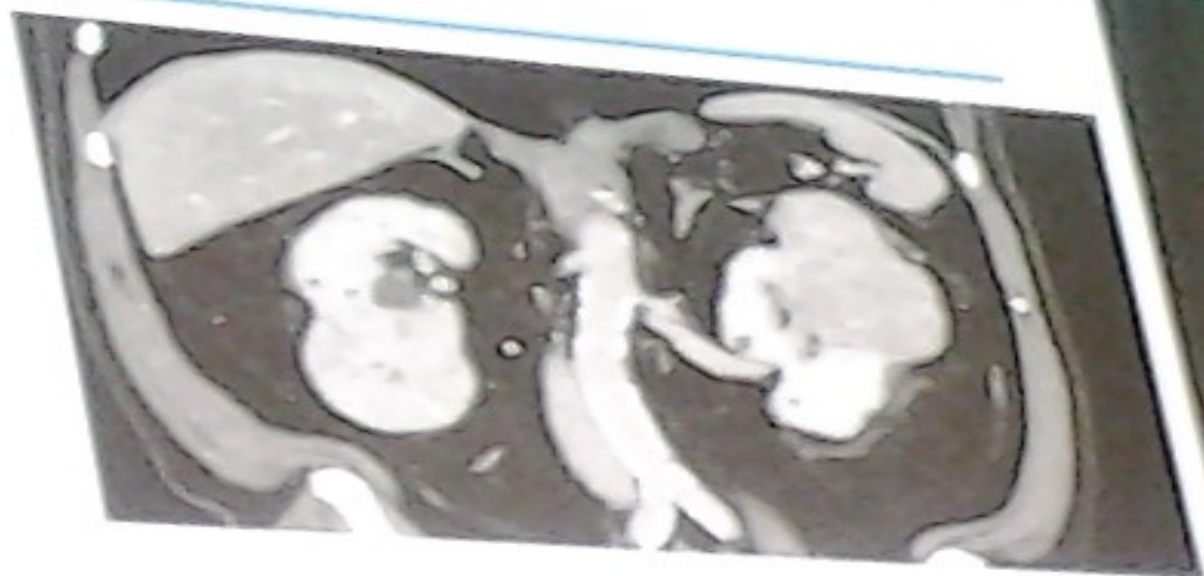
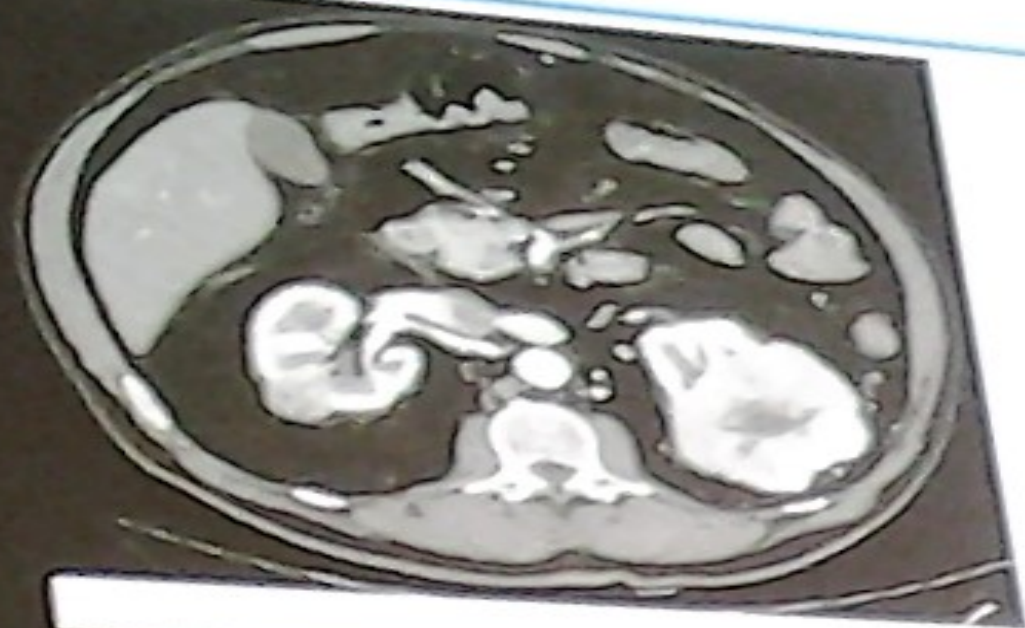


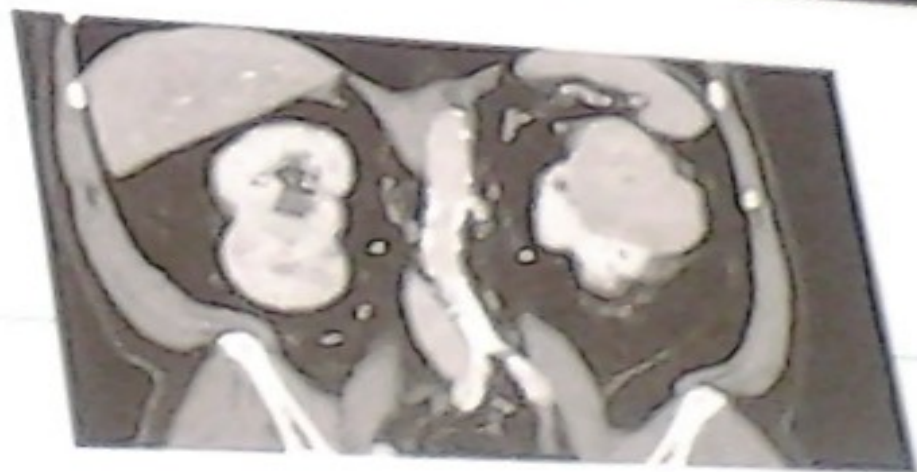
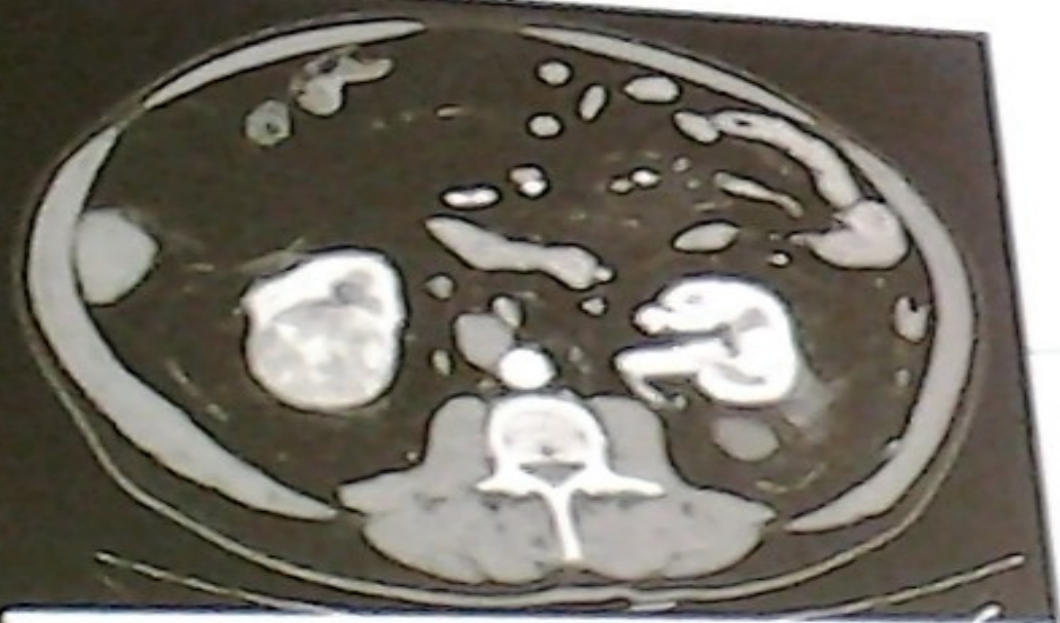
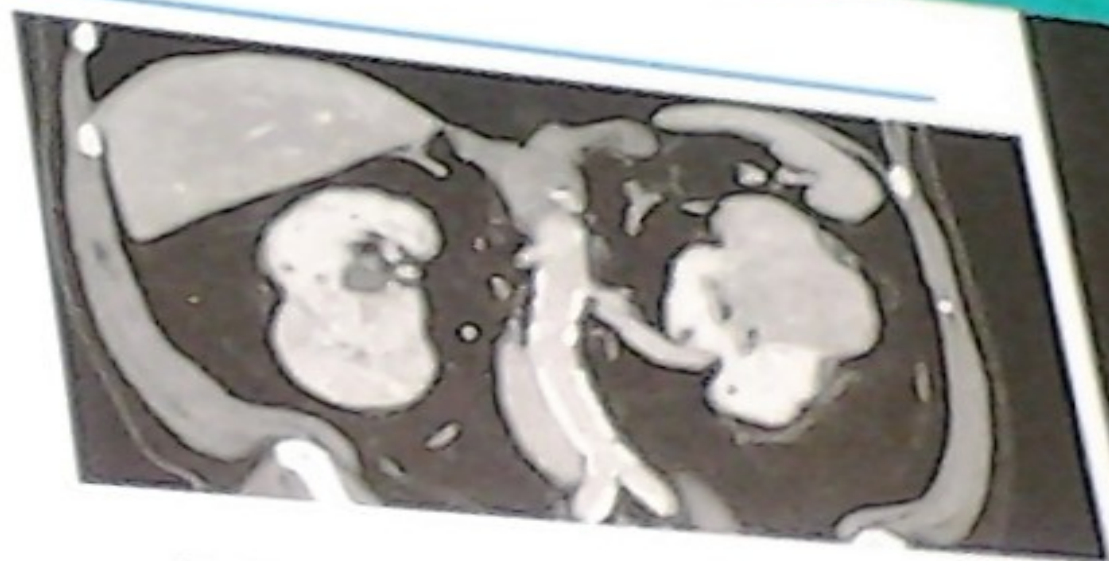
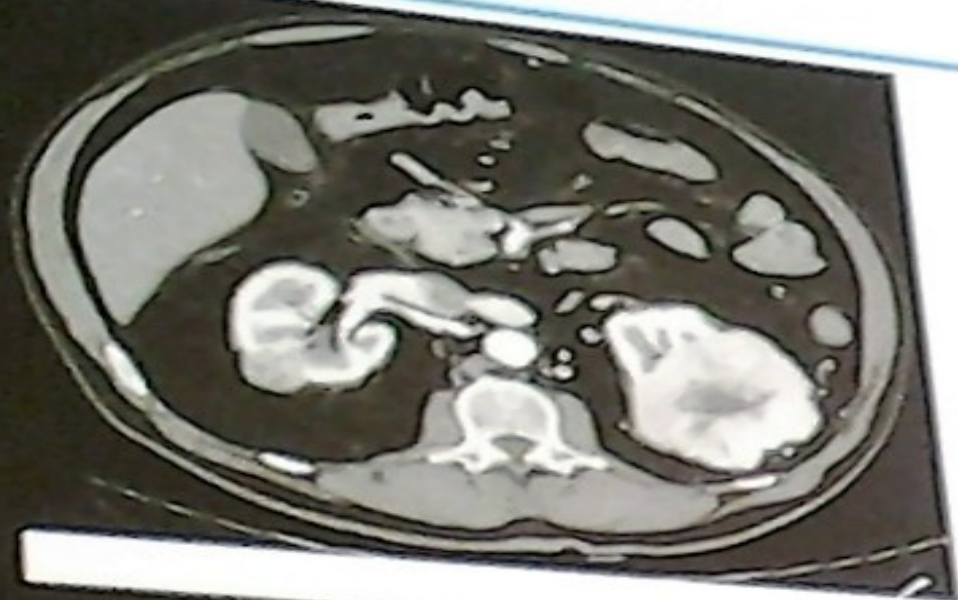
13 εκπαιδευτική εβδομάδα Ε.Ο.Ε

ΒΛΑΧΙΩΤΗΣ ΙΩΑΝΝΗΣ M.D. PhD FEBU

Συν/της Δ/ΤΗΣ Ουρο/γικής ΜΕΤΑΞΑ



Radboudumc



Radboudumc

Thorax^ThorAbd_NON_CNTR (Adult
Thor+Abd 5.0 B31f medium smooth -
Gastrografi

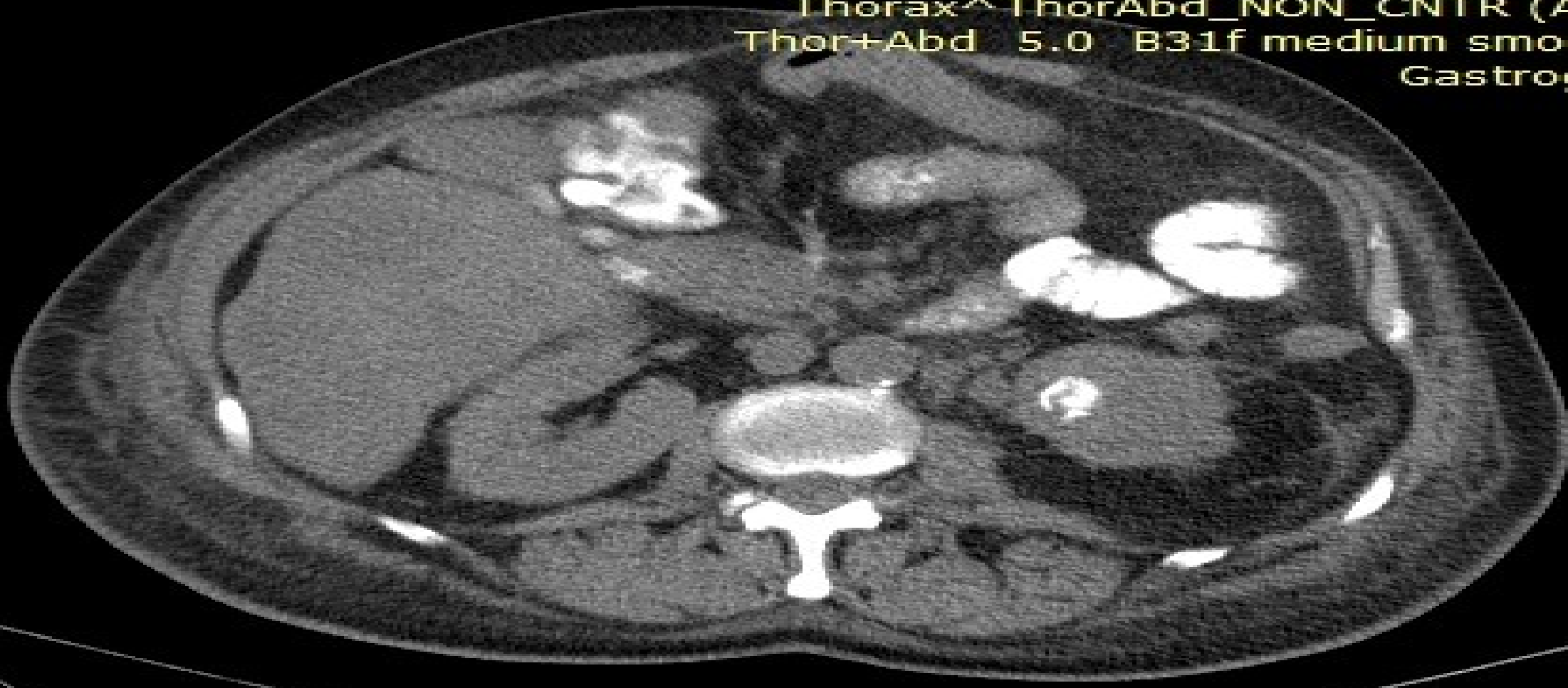


R

L

100318
26/1/1944
Metaxa Hospit

Thorax^ThorAbd_NON_CNTR (Adult
Thor+Abd 5.0 B31f medium smooth
Gastrograf



R

L

WL: 52 WW: 379
: 5.0mm L: 185.0mm

P

375mA 100k
25/1/2018 1:07:09

100510

26/1/1944

Metaxa Hospit

Thorax^ThorAbd_NON_CNTR (Adult
Thor+Abd 5.0 B31f medium smooth
Gastrograf

R

L



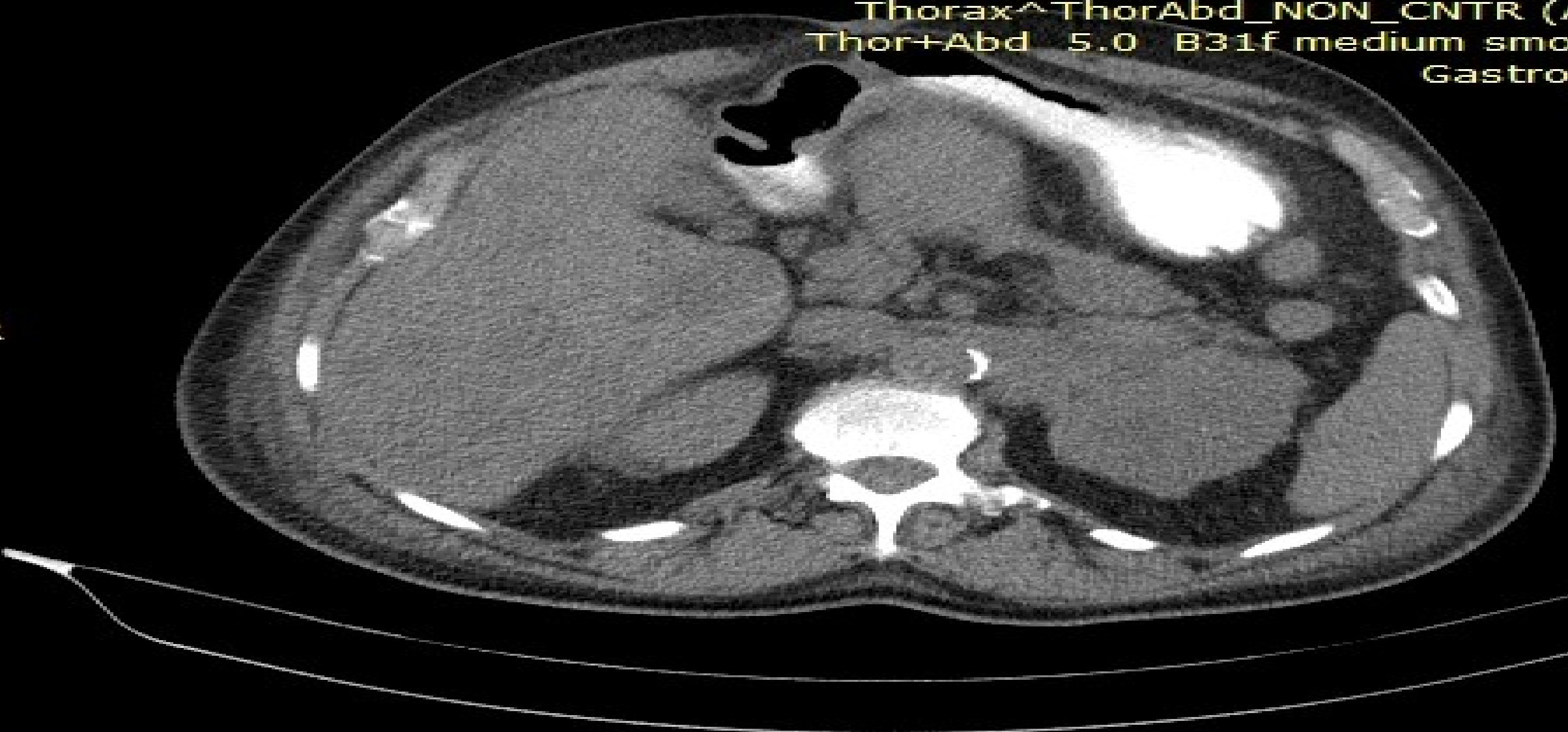
WL: 52 WW: 379
: 5.0mm L: 200.0mm

P

380mA 100k
25/1/2018 1:07:09

26/1/1944
Metaxa Hospital

Thorax^ThorAbd_NON_CNTR (Adult)
Thor+Abd 5.0 B31f medium smooth
Gastrogr

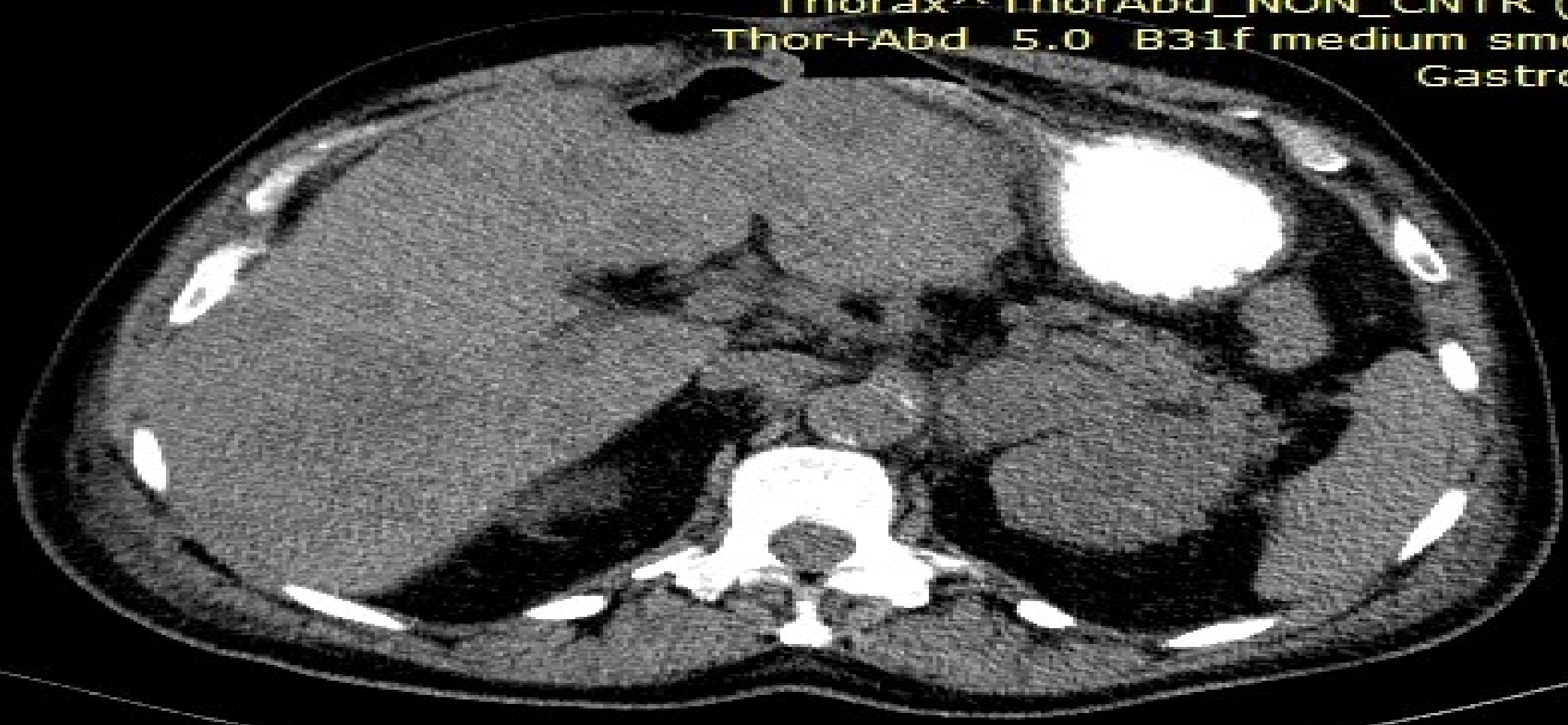


L: 52 WW: 379
5.0mm L: 220.0mm

P

371mA 100
25/1/2018 1:07:09

Thorax^ThorAbd_NON_CNTR (Ad
Thor+Abd 5.0 B31f medium smoot
Gastrogr



26/1/1944
Metaxa Hospit

Thorax^ThorAbd_NON_CNTR (Adult
Thor+Abd 5.0 B31f medium smooth
Gastrograf



L: 50 WW: 244
: 5.0mm L: 290.0mm

P

292mA 100kV
25/1/2018 1:07:08

26/1/1944

Metaxa Hospit

Thorax^ThorAbd_NON_CNTR (Adult

Thor+Abd 5.0 B80f-ultra sharp lun

Gastrograf

R

L

L: -510 WW: 1840 [D]

: 5.0mm L: 335.0mm

P

259mA 100k

25/1/2018 1:07:08 p



100510
26/1/1944

Metaxa Hospit

Thorax^ThorAbd_NON_CNTR (Adult
Thor+Abd 5.0 B31f medium smooth

Gastrograf

R

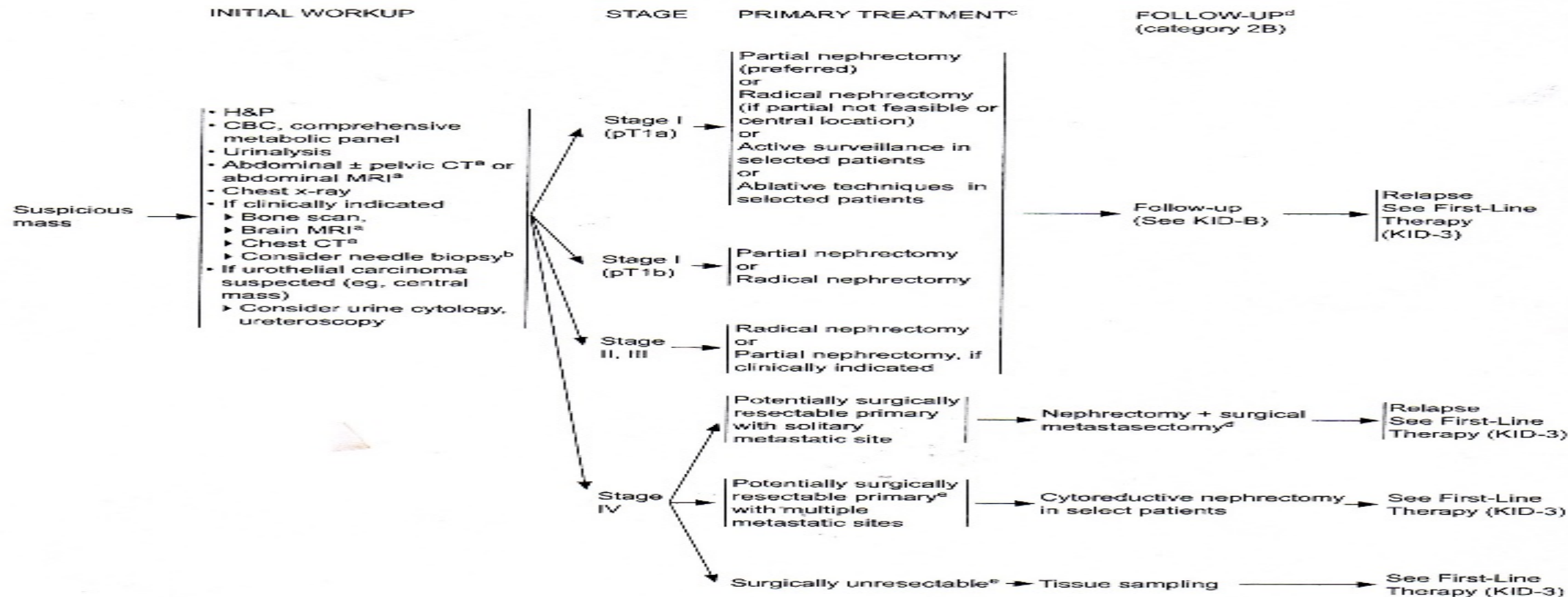
L

WL: -400 WW: 1500 [CT Lungs]

P

258mA 100kV





^aImaging with contrast when clinically indicated.
^bBiopsy of small lesions may be considered to obtain or confirm a diagnosis of malignancy and guide surveillance, cryosurgery, and radiofrequency ablation strategies.
^cSee Principles of Surgery (KID-A).
^dNo single follow-up plan is appropriate for all patients. Follow-up should be individualized based on patient requirements.
^eIndividualize treatment based on symptoms and extent of metastatic disease.



National
Comprehensive
Cancer
Network

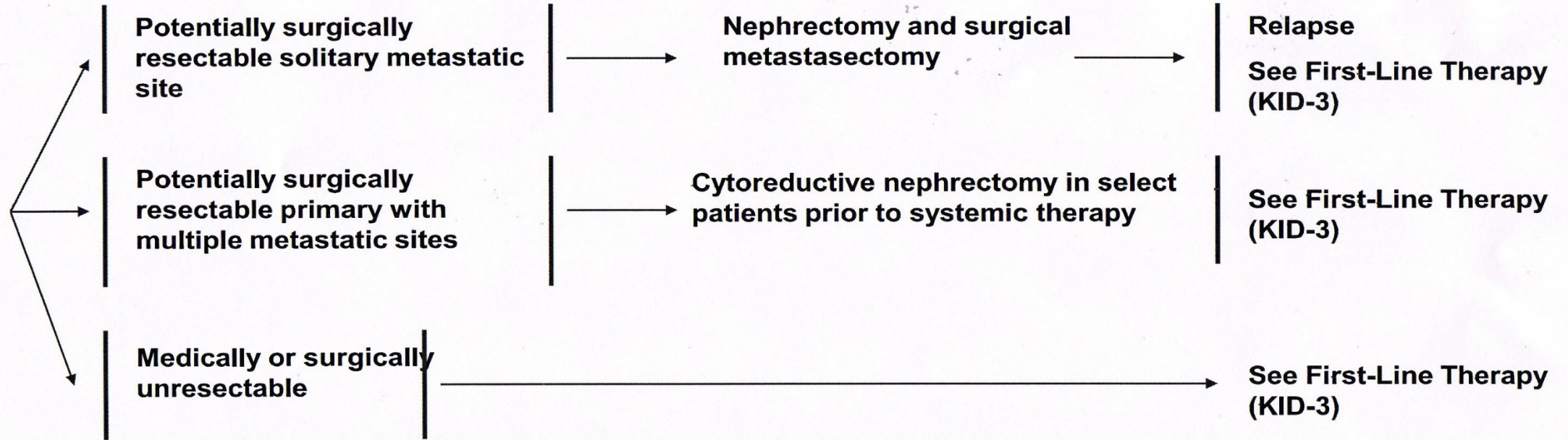
NCCN Guidelines Version 2. 2012

Kidney Cancer

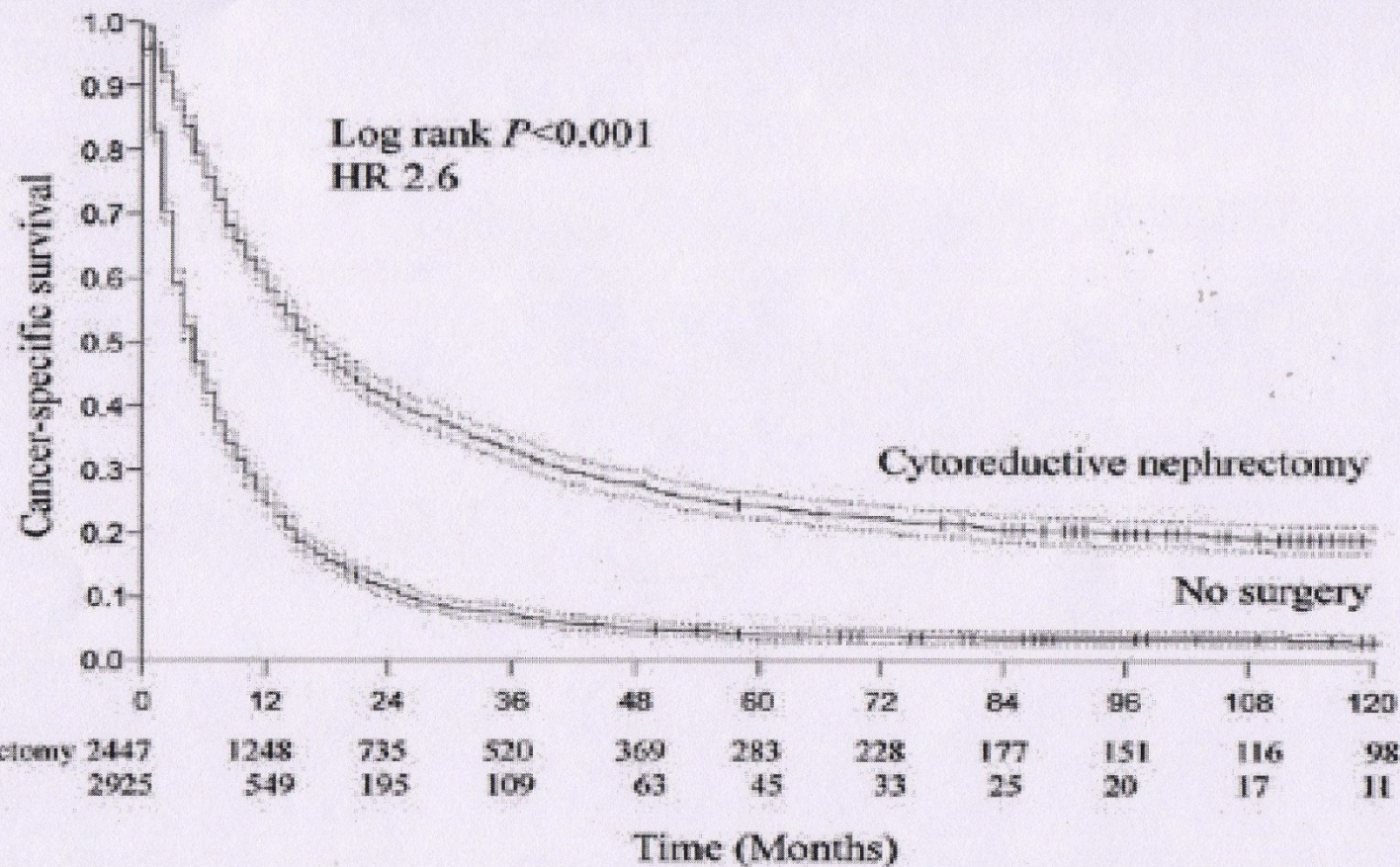
STAGE

PRIMARY TREATMENTS

Stage IV



SEER Database Assessment of Cancer-Specific Survival Cytoreductive Nephrectomy vs. No Surgery for mRCC



Time (years)	Cytoreductive Nephrectomy (%)	No Surgery (%)
1	58.1	24.2
2	40.8	11
5	24.3	4.1
10	18.8	2.9

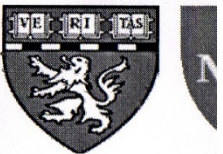
Without Nephrectomy:
 2.5 x increased overall mortality
 2.5 x increased *cancer-specific* mortality.

HR 2.6 $p < 0.001$



- **Study source:** National Cancer Data Base (NCDB)
- **Study**
Patients with mRCC treated with TT between years 2006 and 2013:
 - 5,374 (34%) CN + TT
 - 10,016 (66%) TT alone
- **Intervention:** CN vs. no CN
- **Main outcomes measures:** Overall Survival
- **Statistical analysis:**
 - Temporal trend analysis using estimated annual percent change (EAPC)
 - Multivariable logistic regression analyses for prediction of CN
 - Cox regression for prediction of any death and incremental survival analysis
 - Sensitivity analysis using propensity score

popu



Conclusions

- **Only 3/10 patients with mRCC treated with TT undergo CN**
- **Several patient and sociodemographic factors were associated with receipt of CN, regardless of clinical factors.**
- **OS is more favorable in patients who underwent CN and TT compared to TT alone**
- **A careful patient selection remains warranted**



Criteria for selection of patients to undergo cytoreductive nephrectomy

- **>75% debulking can be achieved**
- **Absence CNS, multiple bone or liver mets**
- **Adequate cardiopulmonary reserve**
- **ECOG performance status 0 or 1**



Prediction of Poor Survival and mRCC

- **Poor Performance Status (ECOG \geq 1)**
- **LDH $>$ 1.5 normal**
- **Low hemoglobin**
- **High Calcium ($>$ 10 mg/dl)**
- **No history of nephrectomy**

**MSKCC Database,
670 patients
1975 – 1996**



Can we Better Select Patients mRCC for CRN?

IMDBC for RCC Poor Prognostic Features

Anemia

Thrombocytosis

Neutrophilia

Karnofsky <80%

<1 year from diagnosis to treatment

Eur Urol 2014 ;65: 723

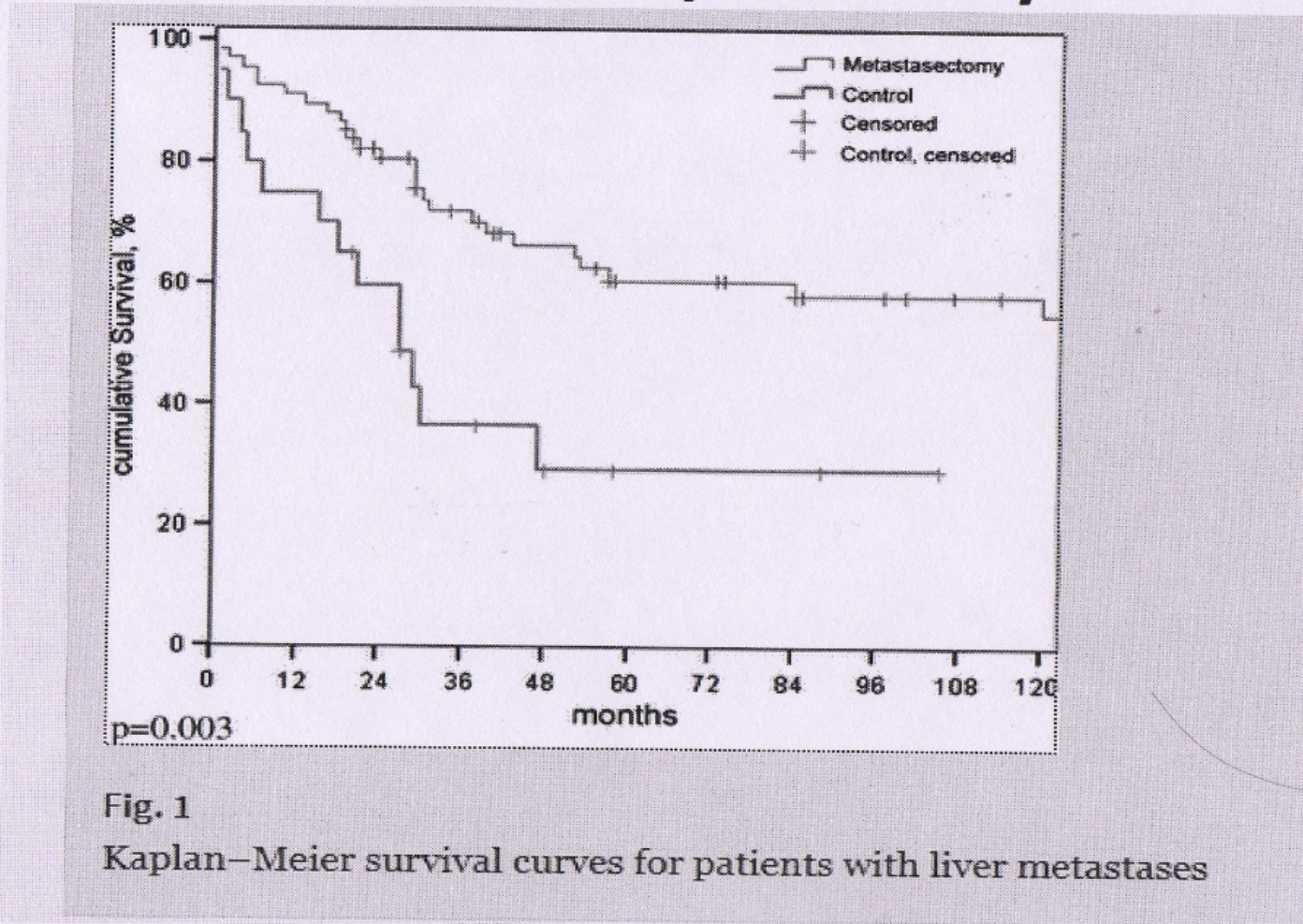


Location of Resected Metastasis

- **Lung: 5 yr survival 40% Isolated low vol synchronous disease; 60% metachronous**
- **Bone: Spine, pelvic femur, humerus 5yr survival 35%**
- **Liver: 5 yr survival 15%**
- **Lymph nodes: 5 yr survival synchronous 12%;metachronous 30%**
- **Isolated pancreas, adrenal: 5 yr survival 60 -66%**



Liver resection prolongs survival in RCC mets in 68/88 pts 12 year results



- Staehler et.al world j. of Urology (2010) 28:543

Metastasectomy in mRCC

- **99 patients lung (62%); bone (34%); Liver (23%); other(27%)**
- **Any metastasectomy med survival 55 mo; no metastasectomy 25 mo**
- **5 year survival any metastasectomy 50%; no metastasectomy 38%**
- **Disease free status only 21%**



1977
1977



1977

**PRINCIPLES OF SURGERY
FOR GERM CELL TUMORS**

- RPLND is the standard approach to the surgical management of NSGCTs in both the primary and post-chemotherapy setting.
- A template dissection or a nerve-sparing approach to minimize the risk of ejaculatory disorders should be considered in patients undergoing primary RPLND for stage I nonseminoma.
- The “split and roll” technique in which lumbar vessels are identified and sequentially ligated allows resection of all lymphatic tissue around and behind the great vessels (ie, aorta, IVC) and minimizes the risk of an in-field recurrence.

Post-Chemotherapy Setting

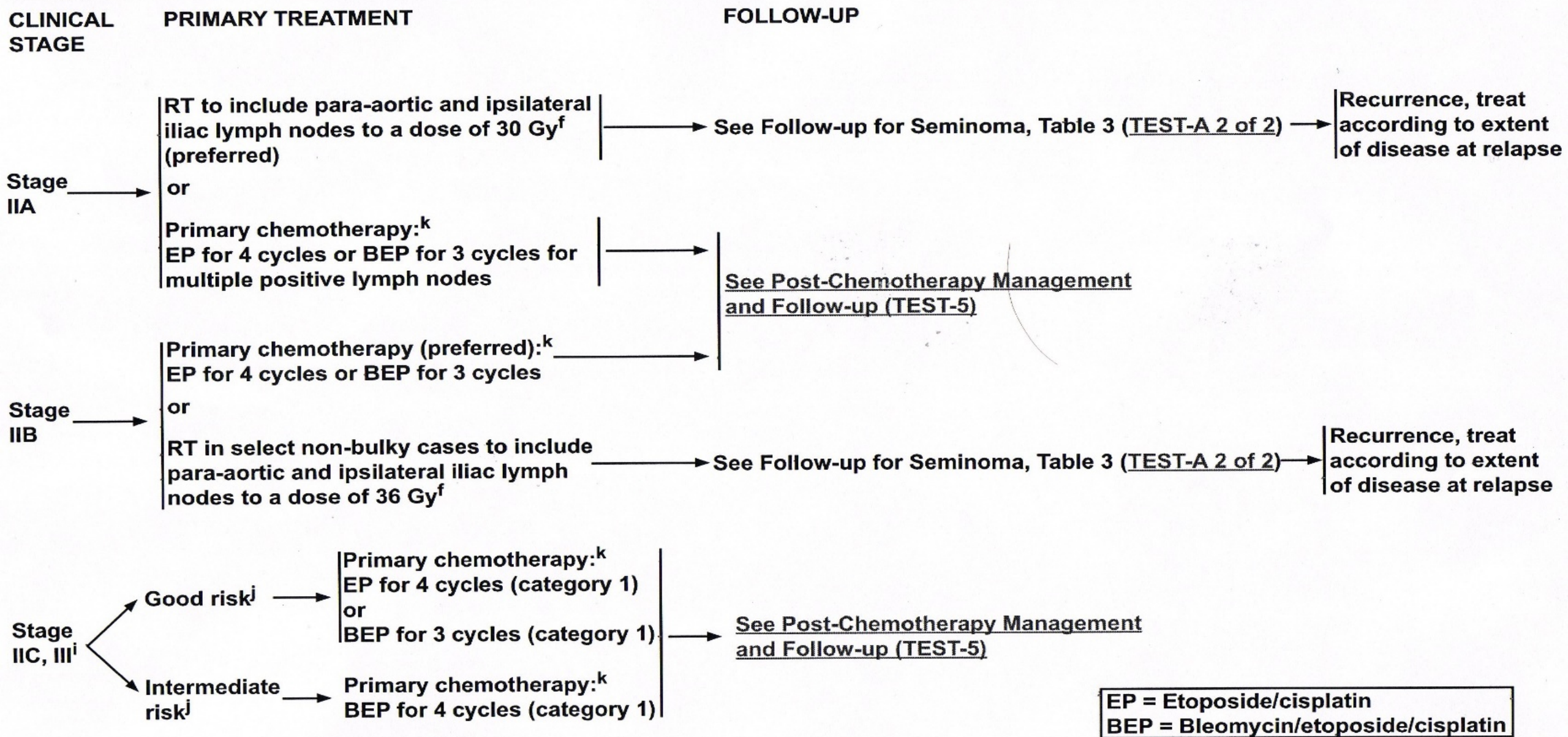
- Referral to high-volume centers should be considered for surgical resection of masses post-chemotherapy.
- Completeness of resection is an independent and consistent predictive variable of clinical outcome. In post-chemotherapy RPLND, surgical margins should not be compromised in an attempt to preserve ejaculation. Additional procedures and resection of adjacent structures may be required.
- Post-chemotherapy RPLND is indicated in metastatic NSGCT patients with a residual retroperitoneal mass following systemic chemotherapy and normalized post-chemotherapy serum tumor markers.
- A full bilateral template RPLND should be performed in all patients undergoing RPLND in the post-chemotherapy setting, with the boundaries of dissection being the renal hilar vessels (superiorly), ureters (laterally), and the common iliac arteries (inferiorly).

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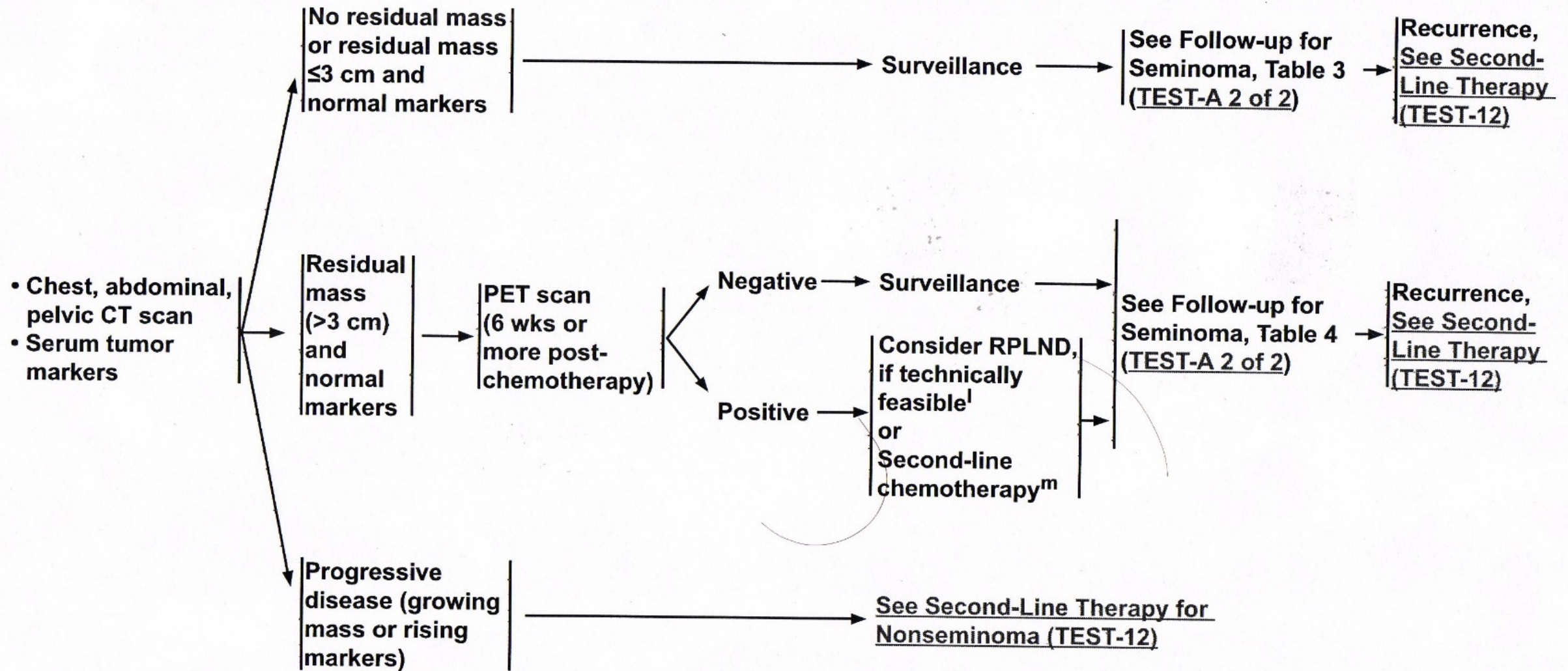
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STAGE IIA, IIB, IIC, III AFTER PRIMARY TREATMENT WITH CHEMOTHERAPY

POST-CHEMOTHERAPY MANAGEMENT

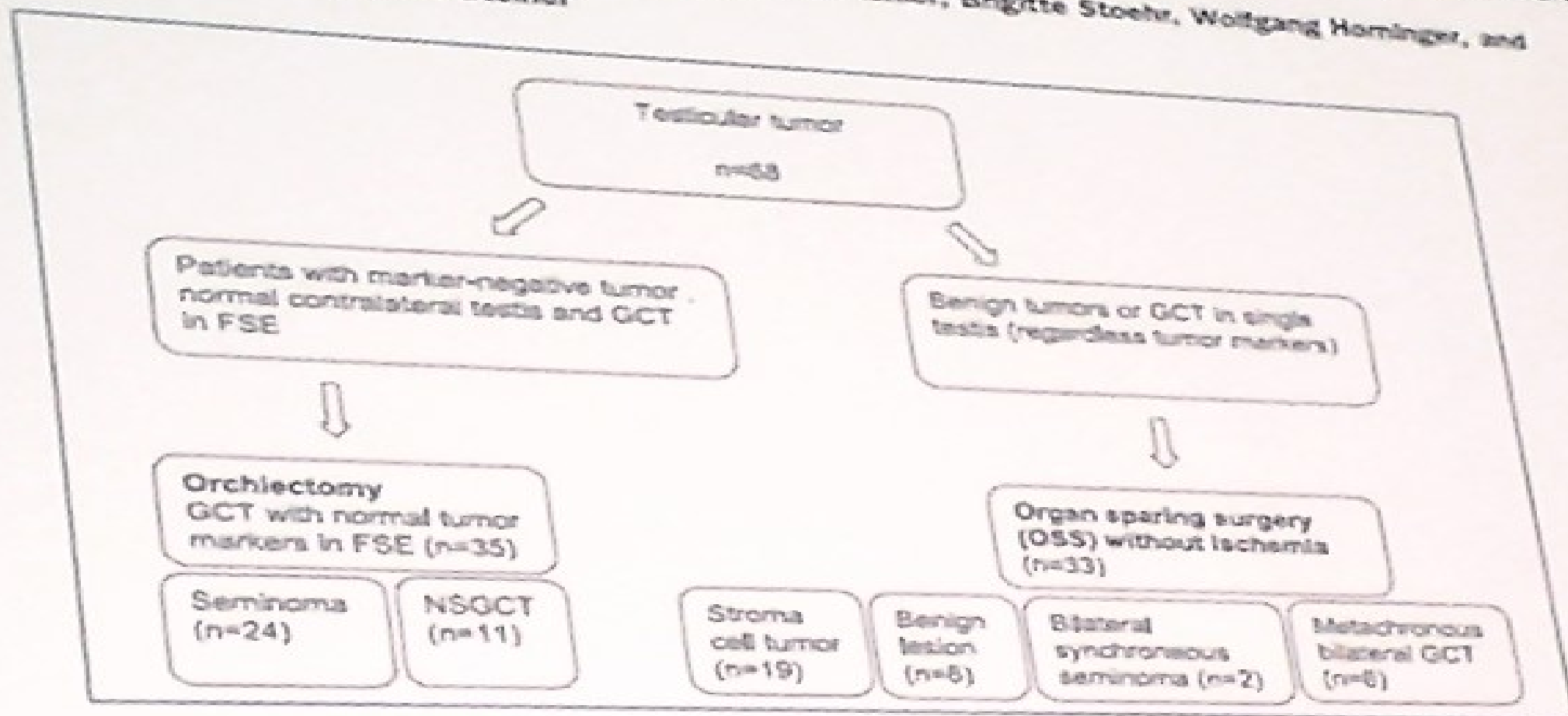
FOLLOW-UP





Organ Preservation Technique Without Ischemia in Patients With Testicular Tumor

Nicolai Leonhartsberger, Renate Pichler, Brigitte Stoehr, Wolfgang Hominger, and Hannes Steiner



ORGAN PRESERVATION WITHOUT ISCHEMIA IN PATIENTS WITH TESTICULAR TUMOR(No 68)

- Patients with marker(-), normal contralateral testis and GCT in frozen section (FSE)
- Orchiectomy (No 35)
- GCT markers normal
- FSE : seminoma (No 22), NSGCT (No11)

ORGAN PRESERVATION WITHOUT ISCHEMIA IN TESTICULAR CANCER

- Benign tumors or GCT in single testis (regardless tumor markers)
- Organ spare surgery without ischemia (No 33)
- Stroma cell (No19), benign lesion (No6), bilateral synchronous seminoma (No2) , metachronous bilateral GCT (No6)

Author	years	patients	Follow-up (Months)	NED
Heidenreich et al.	1994-2000	73	91 (3-191)	72 (98,6%)
Steiner et al.	1994-2002	30	46,3	30 (100%)
Stefani et al.	2004-2011	20	35	20 (100%)
Gentile et al.	2009-2013	15	19,2	15 (100%)
Bojanovic et al.	1996-2013	24	51 (7-178)	24 (100%)
Bojanic et al.	2010-2015	28	33	28 (100%)
Lawrentschuk et al.	1994-2009	30	5,7 Jahre	30 (100%)



The role of magnetic resonance imaging in the local staging of penile cancer.

- A good correlation between radiologic and histologic staging was achieved with an overall kappa value of 0.75 ($p < 0.001$).
- Stage-specific sensitivities and specificities were calculated: T1 (85%; 83%), T2 (75%; 89%), and T3 (88%; 98%).
- MRI accurately predicted corpora cavernosa invasion in all cases of pathologically proven disease.









FA



IRA

