at the level of transsection. Before final retrieving the organ 6 cm muscle-splitting incision was made in left inguinal area.

Results: Warm ischemia time in both cases did not exceed over 2 minutes. Operation time was 210 and 190 minutes and the blood loss was 250 and 100 ml, respectively. The condition of ureters and the vessels in both retrieved kidneys were excellent and it allowed for easy and safe anastomosis with internal iliac vessels and bladder. The postoperative courses were uncomplicated, slightly elevated creatinine level was only observed up to 1.17 and 1.37 ng/ml. The kidneys were implanted in transplantological departments and their immediate function was noted. Currently both donors and recipients are well.

Conclusions: Living donor nephrectomy is a challenging and difficult procedure which should be performed only in centers with experience in laparoscopy of upper urinary tract. Despite efforts of many organizations the situation in Poland concerning organ donation is not satisfactory. One of the reason may be the fear of surgical trauma caused by open nephrectomy and the lack of knowledge about health condition after kidney donating. Applying the laparoscopic approach for living donor nephrectomy can have a positive effect on rate of kidney donation in Poland.

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Natural history of renal tumors in von Hippel-Lindau syndrome

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Introduction and Objectives: The von Hippel-Lindau (VHL) disease is a hereditary cancer predisposition syndrome with autosomal dominant pattern of inheritance, with high penetrance but variable expression, dependent mostly on age. Its prevalence is 1:39 000–1:53 000. The VHL gene, localized to chromosome 3p25–26 belongs to suppressor genes and was identified in 1993. Affected individuals have a risk of cancer and tumor-like lesions, including retinal angiomas, hemangioblastomas of the central nervous system, renal cysts, renal cell carcinomas (RCC), pheochromocytoma, epididymal cysts and cystadenomas, liver and pancreatic cysts. Morphologically renal lesions vary from simple cysts, through hyperplastic cysts with multiple cell layers and cysts containing clear cell carcinoma, to solid renal lesions. Cysts are usually multiple, bilateral in 30%, mostly asymptomatic. They precede solid lesions about 3–7 years. Solid lesions are always RCC. In 10% RCC is a first diagnosed lesion of VHL. Cumulated risk of RCC in 6th decade is ~70%. RCC is a leading cause of death in VHL patients [1–3]. Clinical features of RCC in VHL syndrome comprise multifocality, bilateral lesions, usually with dense fibrotic capsule, rare metastases especially if primary tumor smaller than 3–7 cm, lower grading, and longer 10 years survival comparing with sporadic RCC. It occurs about 20 years earlier than sporadic RCC. Mean rate of growth for solid renal lesions according to a few papers oscillates from 0.26 cm/year (range 0–1.2) [1], through 0.54 (0.26–0.9) [3] to 1.6 (0.2–2.2) [2].

Material and Methods: Retrospective analysis of radiological documentation of the biggest solid lesions of 5 patients with VHL was done. Mean value of the rate of tumor growth for individual patient and mean value for all the group were counted.

Results: The rate of tumor growth for individual patient shows table 1.

Table 1: The rate of tumor growth for individual patient

Patient	1	2	3	4	5
Rate of growth (cm/year)	0.93	1.7	0.71	0.18	0.8

Mean value for all the group is 0.86 cm/year.

Conclusions: All observed renal solid lesions increased with time. The rate of tumor growth in our study is similar to results from the literature. Big differences of studied value necessitate individualized therapeutic approach to each patient.

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The results of multidisciplinary treatment of metastatic renal cell carcinoma

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Introduction and Objectives: Metastatic renal cel carcinoma (mrcc) is chracterised by the highest percentage of deaths of all urological tumours.5-year disease specific survivals after nefrectomy in this group do not cross 10%.

Material and Methods: Group of 138 patients with MRCC: 99 men and 39 women treated in years 1999–2007 is presented (age 30 to 85 years, 59 mean).Organ metastases in 124 patients were diagnosed, in 98 to local lymph nodes (in 14 patients solely), in 84 patients both lymph nodes and organ metastases were detected.T stage of patients presents as follows: 26 T4, T3B 29, T3A 40, T2 22 and T1 23 (bilateral tumours-7 patients). Patients were divided into groups: I-only nehrectomized (15), II-nephrectomized with adiuvant immunochemotherapy (ICHTH) (18), III-renal artery embolisation with subsequent nephrectomy (24). IV-renal artery embolisation with subsequent nephrectomy and adiuvant ICHTH (21), V-only palliative embolisation of renal artery (60).

Results: The mean observation time was 25.4 months (1.5–145). 76 patients (55.1 %) died.Tumour dependent survival time was 14.25 m.(1–145). Progression of the disease was observed after 10.9 months (1 m-11 years). Observation time, progression free survivaltime and tumour dependant survival time counted: Group I-observation time 20.1 months (3.9–56.1), progression time 5.3 months (2.4–25.3), tumour dependant survival time 10.4 months(3.9–25.3), Group II-observation time 22.4 months(3–62.7), progression time 10.8 months (1 to 48.7), tumour dependant survival time 18.2 months (3 to 44.9).Group III-observation time 22.8 months (1.5–85.8), progression time 6.6 months (1–18.3), tumour dependant survival 9.1 months (2.2–24.2), Group IV-observation time 28.6 months (7.8–76.8), progression time 8.5 months (1–25.2), tumour dependant survival 26 months (7.8–76.8), Group V-observation time 11 months (1–53.5), progression time 8 months (1–30). Observation results were compared to data from the literature relating the patients survival with metastatic RCC (6 m mean).

Conclusions: 1. Multidisciplinary MRCC treatment including: renal artery embolisation, subsequent nephrectomy and the adiuvant ICHT may lengthen the tumour dependant survival time. 2. Palliative embolisation of renal artery may slighty lengthen survival time of MRCC patients in comparison to symptomatical treatment. 3. Significantly longer survival time may be reached for good general condition patients (WHO 1–2). 4. Over 3 year observation time in some patients treated only by renal artery embilisation, without essential deterioration of their general condition, suggests nephrectomy reconsideration in certain cases.