

**Conclusions:** All stages management were compliant with the current available guidelines except for mixed tumour stage I. Highly curative rates can be attained by all three modalities. Standard treatment with radiotherapy is challenged by surveillance and chemotherapy. Higher percentage of cases with mixed cell tumour as well as Stage II seminoma.

#### Poster session 4: Benign and Malignant renal diseases and Kidney transplant

Friday, 23 October 2009, 14:30–16:30

Poster room 1

#### C51

##### Nephron sparing surgery for renal cancer – expanding indications and advancement in minimal invasive surgery

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**Introduction and Objectives:** A program for the nephron sparing treatment of kidney tumours was established at our institution in January 1992, laparoscopic approach is used since September 2004. As of June 2009, 302 open resection and 68 laparoscopic resection have been accomplished.

**Material and Methods:** Since 1992 to June 2009 1340 patients were treated for renal tumours, 370 (27.6 %) underwent tumour's resection.

**Results:** Nephron sparing surgery composed approximately 23.5±11.8 % per a year. It was 8.0 % in 1992, 25.5 % in 2000 and 40.3 % in 2008. There is so higher application of nephron sparing surgery and lower in nephrectomy, regress equation for nephrectomy:  $y = -0.02x + 0.9552$  vs.  $y = -0.02x + 0.0448$  for resections; reliability value 0.8123. We did not find any statistical significant differences in operation time (mean 115±28 min), but there is a higher application of category T1b (0 % in 1992 vs. 22.7 % in 2000 vs. 32.3 % in 2008). We provided only open surgery for T1b.

**Conclusions:** Way to relatively good results of nephron sparing surgery is in careful selection of tumours using two phase CTA and superspecialisation of surgeon. OR still remains gold standard in nephron sparing surgery mainly in bigger tumours. The work was supported by Czech government research project MSM 0021620819.

#### C52

##### Prognostic factors and survival of clear cell renal carcinoma patients with bone metastasis

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**Introduction and Objectives:** The clinical factors influencing the survival of renal clear cell carcinoma patients with bone metastasis was examined in a retrospective study setting.

**Material and Methods:** We analyzed the data of 65 patients operated between 1990 and 2008. Descriptive statistical method was also utilized, clinical data regarding survival were evaluated with Life table and Kaplan-Meier method, moreover, for multivariable analysis Cox regression method was applied.

**Results:** Based on Kaplan-Meier curves age, sex, clinical symptoms, pathological fracture, progression to the soft tissues, localization of tumor (spinal metastases are excluded), size of metastasis, whether the occurrence of multiplex metastases is multiorganic or localized in the skeletal system only, and the stage and grade of the primary renal cancer did not influence the survival. The survival was significantly improved if the bone metastases were late onset (occurred more than four years after the renal surgery); moreover, it was solitary, Fuhrmann grade 1 and radical surgery was performed. Based on Cox regression analysis, the results indicated that survival after bone surgery was influenced by the multiplicity and grade of metastasis and radicality of the surgery, whereas survival after nephrectomy was significantly influenced by the time of onset and grade of metastasis. As for the patients surviving bone surgery more than five years, there were more patients who had solitary, grade 1 metastases operated on by radical surgery than in the group where patients died earlier than five years. When the solitary metastasis was radically removed, 75.0% of the patients survived the first, 61.6% the second, 51.3% the third, 39.9% the fourth, 35.5% the fifth postoperative years. If the metastasis was multiple or the surgery was not radical, the 40.9% of patients survived the first, 16.0 % the second, 6.8% the third, 3.4% the fourth and none of the patients survived the fifth year.

**Conclusions:** According to our results we can conclude that in case of multiple or surgically unremovable metastases, minimal invasive surgery is much preferred. Moreover, in the case of solitary, low grade, operable metastases especially when they occur more than four years, we have to go ahead for a radical removal since in this way longer survival time could be expected (more than 10 years in certain cases). According to our best knowledge, the prognostic relevance of Fuhrman grade of bone metastases was not published before.

#### C53

##### Risk factors in renal cell carcinoma with venous extension

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**Introduction and Objectives:** Venous extension is a particularity of RCC and is registered in 5–25% of the cases, 1% having atrial extension. Identification of the risk factors, especially the influence of the adherence and the level of the thrombus in patient's survival provides valuable informations for the treatment and prognosis of these patients.

**Material and Methods:** Two cohorts of patients were studied: Cohort A – 108 patients with RCC and subdiaphragmatic venous extension (renal vein – RV and subdiaphragmatic inferior vena cava – IVC) operated in our center between January 2000 – December 2006. Cohort B – 26 patients with RCC and supradiaphragmatic venous extension operated in our clinic between 1994 and 2007. Statistic significance of the potential risk factors was evaluated with several tests: chi<sup>2</sup>, Yates correction of chi<sup>2</sup>, Fisher test, relative risk and confidence interval. The confidence interval was 0.05

**Results:** The main statistic significant survival risk factors were: sarcomatoid feature (p=0,049), Fuhrman grade III and IV (p=0,00003), tumoral stage T4 (significance only in cohort B – p=0,033); lymph node metastases N (p=0,0047), distant metastases M (p=0,00005), tumoral stage IV (p=0,00001). There were not validated as statistic significant risk factors: the sex of the patient (p=0,668); left sided tumour (p=0,420), tumour size >10 cm (p=0,540), adherence of the thrombus (p=0,214) and the level of the thrombus (subdiaphragmatic IVC vs RV p=0,2834; supradiaphragmatic IVC vs RV – p=0,2163; supradiaphragmatic IVC vs subdiaphragmatic IVC p=0.36).