The Elderly Urology Patient

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Common Urological Conundrums in the Elderly Patient

- Small renal masses
- Elevated PSA
- Localised prostate cancer
- Lower urinary tract symptoms
- Asymptomatic renal stones
- Localised bladder malignancy
Small renal masses

- Renal lesions <4cm (pT1a)
- Incidental finding on imaging
- 20% benign, many indolent
- Only 20-30% demonstrate aggressive features
- Risk of metastatic disease in <4cm lesion is <1%
Not all T1a kidney tumours were created equal…
Small renal masses

- How do we identify the lesions that warrant treatment?
  - Serial imaging
  - Renal biopsy
Small renal masses

- Treatment options:
  - Surveillance
  - Partial nephrectomy
    - Robotic, laparoscopic, open.
  - Radical nephrectomy
  - Ablation
    - RFA, microwave
  - Radiation

- Dependent on tumour characteristics
Case 1

- 92 year old lady
- USS to investigate vague abdominal pain
- Significant co-morbidities
- Options:
  - Surveillance
  - Discharge
Case 2

- 72 year old male
- Treated hypertension, otherwise fit.
- eGFR 65
- Options:
  - Partial nephrectomy
  - Observation
  - Radical nephrectomy
  - Ablation
Case 3

- 84 year old lady
- Living independently
- Referred 2014 with 22mm lesion

Options
- Observation
- RFA
- Stereotactic radiation
Case 4

84 year old lady

Living at home with assistance, but frail.

Not amenable to ablation.

Options:
Radical nephrectomy.
Palliative management.
Case 5

- 82 year old man
- 30mm right lower pole mass observed for 2 years – no change on imaging.
- Booked for annual CT.
- Represented 6 months later with haematuria
- CT showed 6cm lesion, nodal disease and pulmonary metastases
- Laparoscopy – unresectable
- Palliative radiation
Summary: Small renal masses

- 20% benign.

- Many will not require treatment, especially in the elderly

- Key is determining which lesions require intervention.

- 3.5cm is the upper limit for ablative therapies.
USANZ PSA screening guidelines:
- Offer to men 50-69 years, or with a life expectancy of >10 years with appropriate counseling.

When NOT to order a PSA
- Suspected UTI
- Acute deterioration in LUTS
- Acute urinary retention
- Recent catheterisation or instrumentation

If there are clinical concerns in any of these scenarios a DRE is more appropriate
Case study 1

- 83 year old man.
- Admitted under physician with fevers + exacerbation of LUTS.
- Urine M/C/S – E. Coli UTI.
- PSA sent on day of admission.
- Previously saw Urologist 5 years ago – negative TRUS biopsy.
Case study 1

- PSA 79
- Anxious +++
- Concerned family +++
- DRE – 80g, benign.
- Bone scan negative
- 3 weeks later – PSA 9.9
Case study 2

- 82 year old man.
- Admitted with acute on chronic renal failure.
- USS showed 700ml bladder with new left hydronephrosis.
- PSA 7.8.
- Treated as bladder outlet obstruction.
Case study 2

- DRE revealed hard, nodular gland.
- Cystoscopy showed malignant occlusion of left distal ureter – stented.
- Channel TURP – Gleason 4+5=9 adenocarcinoma in 100% of resected tissue.
Summary

- Small renal masses
  - Don’t panic!
  - Observation in the 1st instance.
  - Treatment in concerning lesions depends on patient and tumour characteristics.

- PSA
  - Screening tool in men with a life expectancy >10 years.
  - Beware the pitfalls in acute presentations.
  - Should be used in conjunction with clinical examination.