## Paper 13: Cystoscopy guided laparoscopic diverticulectomy

**Abstract**

60-year-old male patient presented with obstructive voiding symptoms. History of TURP done 2 years back. Ultrasound was suggestive of Bladder Diverticular on the Right posterolateral aspect. CECT confirmed the same. Cystoscopy showed large single diverticular 2cm, lateral and posterior to the right ureteric orifice. In view of obstructive voiding symptoms laparoscopic diverticulectomy was planned. During surgery cystoscope with light is kept at the diverticular neck which guided the entire laparoscopic dissection. Only one transfixation stich at neck of diverticular done. Detrusor buttering done over the same.

**Results**

- Operative time was 150 min and blood loss was around 50ml. Patient was started orally on POD0 and irrigation stopped on POD1 and drain removed on POD5. Urethral catheter removed on POD14. Patient is asymptomatic now at 6 months follow up.

**Conclusion**

Laparoscopic nipple valve ureteric reimplantation is an effective and feasible method for reimplantation in dilated ureters, where long tunnels may be required, providing minimally invasive benefits.

**Authors**

Chandra Mohan Vaddi*, Preeti Urology & kidney Hospital & Ramakrishna Padakula, Preeti urology & kidney Hospital

## Paper 16: Laparoscopic nipple valve ureteric reimplantation

**Aims and Objectives**

To evaluate the feasibility of laparoscopic nipple valve reimplantation for obstructed megaureter. Methodology: 35 yr old patient presented with complaints of vague right loin pain for the past 1 year. On evaluation, he was found to have right obstructed megaureter with secondary calculi. Under general anesthesia, using 4 ports, 3 x 10mm and 1 x 5 mm, laparoscopy was done. Right ureter was dissected from pelvic brim to bladder. Ureter ligated at the level of narrowing and cut. Secondary calculi were removed. Bladder was prepared for reimplantation - cystotomy at the dome. The end of the dilated ureter was reflected on to itself to form a everted nipple. The nipple is maintained using interrupted 4-0 vicryl sutures. The reconstructed ureteric end was reimplanted using interrupted 3-0 vicryl sutures. The 'nipple' acts as a valve preventing reflux. Results: The operative time was 150 min and blood loss was around 50ml. Patient was started orally on POD1 and drain removed on POD5. Urethral catheter removed on POD14. Patient is asymptomatic now at 6 months follow up.

**Conclusion**

Laparoscopic nipple valve ureteric reimplantation is an effective and feasible method for reimplantation in dilated ureters, where long tunnels may be required, providing minimally invasive benefits.

**Authors**

Kallappan Senthil*, Urology Clinic; Manickam Ramalingam, PSG Institute of Medical Sciences; Anandan Murugesan, PSG Institute of Medical Sciences; Mizar G Pai, Urology Clinic

## Paper 17: Laparoscopic Madigan prostatectomy

**Introduction**

Open prostatectomy remains the technique of choice in patients with large benign prostate glands. Madigan prostatectomy is the technique of openprostatectomy where the urethral mucosa is preserved. We present the video of laparoscopic Madigan prostatectomy. Methods: The patient is under general anesthesia and placed in a steep Trendelenburg position. A 2-4 cm midline incision just above pubis is made. Retzius space is developed by balloon distension. Five extraperitoneal trocars in an inverted U shape is placed. Periprostatic fat is cleared by blunt dissection and prostate capsule visualised. Transverse incision is made over the capsule after controlling the dorsal venous complex. The plane of cleavage is defined between the adenoma and the capsule with careful blunt and sharp dissection using a harmonic scalpel and suction cannula. Medial aspect of the adenoma is visualised and dissected away from the urethral mucosa. Any inadvertently opened mucosa is closed with 3-0 vicryl and capsular vessels controlled with 2-0 vicryl sutures. Capsulotomy is closed with 2-0 vicryl. Drain is placed. Results: The operative duration was 130 minutes and blood loss was around 100ml. Patient was started orally on POD0 and irrigation stopped on POD1. Urethral catheter removed on POD14 and patient voiding symptoms.

**Authors**

Manickam Ramalingam*, PSG Institute of Medical Sciences; Anandan Murugesan, PSG Institute of Medical Sciences; Kallappan Senthil, Urology Clinic; Mizar G Pai, Urology Clinic

## Paper 24: Laparoscopic Nephrolithotomy for Recurrent Stag Horn Calculus

**Aim**

To demonstrate the feasibility of the procedure for complex calculus disease in a post PCNL kidney

**Methodology**

Cystoscopy does and 5/24 DJ sternal prepalced after doing RGIP. Transperitoneal laparoscopic approach with 4 ports was employed. Two 10mm and two 5mm port were used. The primary port was placed on the lateral border of the rectus abdomens one inch above the umbilicus with a Hassan technique. Two accessory ports of 5mm were placed int he left hypochondriac and the iliac fossa in the midclavicular line. The colon was reflected in the white line and reflected medially. The retroperitoneal space was entered and the gerona facia incised. The ureter was identified and the dissection was carried cephalic and medial to the ureter. Dense adhesions were found in the lower pole and around the renal artery and were dissected with sharp dissection. The artery and vein were dissected separately. A 100 port was placed in the left posterior axillary line midway between the the 12 th rib and the iliac crest. The kidney was dissected all around so as to places a dam to prevent cooling of the adjacent organs. The dam was created with urobag. Cold saline and slush placed on the kidney and the kidney cooled for 20 min after clamping the artery and the vein. Kidney incised 1cm posterior to the lateral edge. The collecting...
Aim: To demonstrate the feasibility of robotic radical nephrectomy with Level II inferior venacaval thrombectomy with use of robotic bull dog clamps Material and methods: 52 year old man with hematuria on evaluation found to have large renal mass with a thrombus in the renal vein extending to inferior venacava (IVC). Patient was placed in right lateral position. Da Vinci Si system with 4 arms was used. Adhesions under the liver was released, colon and duodenum was reflected. Initial dissection was started in the interaortocaval region, the lumbar veiners were encountered and clipped and divided to adequately mobilise the IVC. The renal arteries were identified one by one and ligated with WECK Clips. The IVC was mobilised superiorly upto the edge of the liver. The left renal vein was dissected all around, vascular loops were applied in the infrahepatic IVC , left renal vein and left renal IVC. Robotic bulldogs were applied after synching the venecava with the help of vascular loops. This at allows easier and stable application of the bull dogs. The IVC was then opened and thrombus was extracted. There was a small area of infiltration of the thrombus to the wall of IVC which was excised. The cavotomy was sutured using 6.0 goretex suture. Then all the clamps were released sequentially. The specimen was removed after 6 wks.

Case 2: 72 yr old male with large left pelvic calculi. Lap vicryl using hemlock clips, stone clearance confirmed with post op X-Ray, DJ stent placed. Patient was taken for right LANL. Right DJS placed. Patient in left lateral position for large calculi in normal and pelvic kidneys

Methods: Case 1: 64yrs male presented with management for large complex renal calculi. We present challenging cases of efficacy. In this video presentation we show our technique of transperitoneal approach for clearance remains technically challenging. SWL, PCNL or a combination therapy has limited recorded . A total of 15 patients were treated by the laparoscopic approach. The mean exposure during difficult dissection. Results: The operative and post operative details were the collection and prevent injury to the arterial anastomotic site which was inadvertently intended right lateral wall of bladder. A laparoscopic ultrasound probe was used to detect postero-inferior aspect of the transplant kidney inferiorly extending into pelvis and supra-inferior aspect of the transplant kidney inferiorly extending into pelvis and extending right lateral wall of bladder. A laparoscopic ultrasound probe was used to detect the collection and prevent injury to the arterial anastomotic site which was inadvertently exposed during difficult dissection. Results: The operative and post operative details were recorded. A total of 15 patients were treated by the laparoscopic approach. The mean Aims and Objectives: The management of large complex renal calculi and complete clearance remains technically challenging. SWL, PCNL or a combination therapy has limited efficacy. In this video presentation we show our technique of transperitoneal approach for management for large complex renal calculi. We present challenging cases of laparoscopic Anatomic nephrolithotomy for large Staghorn calculi, lap pyelolithotomy for large calculi in normal and pelvic kidneys Methods: Case 1: 64yrs male presented with right flank pain 6 months duration. CT Urogram showed right staghorn calculi measuring 5.3X4.5cm . Patient was taken for right LANL. Right DJ stent placed. Patient in left lateral position, standard ports inserted, colon reflected, kidney mobilized completely after opening gerota fascia, renal hilum dissected and clamp applied enbluc using laparoscopic satinsky. Nephrosectomy incision given along the brodels line, PCS opened along the line of incision and all the calculus removed. The parenchymal defect closed with continuous 1-0 vicryl using hemlock clips, stone clearance confirmed with post op X-Ray, DJ stent removed after 6 wks. Case 2: 72 yr old male with large left pelvic calculi. Lap pyelolithotomy done. Case 3: 32 yr male with left pelvic kidney calculi, difficult lap
Aims and Objectives: Nodal recurrence is rare after radical nephrectomy for clinically localized renal-cell carcinoma (RCC). It is more common in advanced stages like renal vein or IVC thrombus. Aggressive open surgical resection of isolated nodal recurrence can offer durable local control and potential improvement in cancer-specific and overall survival. We present a video presentation of 3D laparoscopic resection of nodal recurrence after radical nephrectomy for clinically localized RCC. Methods: Case 1: 40 yr old lady presented with nodal recurrence in right paracaval region. This patient had initial IVC thrombus(level 1) which was treated laparoscopically. Multiple Lymph nodes were Resected in the paracaval region. The IVC was partially clamped with Lap satinsky and Lymph node infiltration with IVC wall was resected and IVC sutured laparoscopically. Case 2: 69 yr old male was found to have recurrent nodal mass in the left para aortic region. 3D laparoscopic resection of the recurrent mass was done. The dissection was difficult and the mass was very adherent to surrounding structures. Results: 3 patients underwent laparoscopic resection of ipsilateral nodal recurrence. The mean age of patients was 57 yrs (44–66 yr). All had primary tumors with clear-cell histology. 2 of the 3 patients had IVC thrombus. The mean

Introduction : Bladder exstrophy is a rare condition and primary repair is challenging. An osteotomy is essential for achieving closure when repair is performed after 72 hours of life. We herewith report a case and a video of when repair is performed after 72 hours of life. baby, presented with bladder exstrophy and constant leakage of urine. On examination, bladder mucosa was clearly visible with areas of epithelialization; both ureteric orifices were clearly seen with naked eye. Baby also has epispadias and bilateral undescended testis. X-Ray of pelvis revealed pubic diastasis. The baby was thriving well and was taken up for surgery. Primary repair of bladder and epispadias was performed with bilateral anterior pubic ramus osteotomy (video). GalloWS traction was applied for postoperative immobilization and the baby tolerated the procedure well. After 3 weeks the healing was excellent with no fistula/ wound dehiscence and the patient is planned for follow up for bladder neck repair and orchidopexy later. Conclusion : Bladder exstrophy management is challenging and involves multiple steps. The options available for osteotomy include: anterior pubic ramus, innominate and posterior iliac osteotomies. The case is being presented for its rarity and to demonstrate the operative steps.

(a) Introduction and Objectives: Pyeloplasty remains the gold standard therapy in the treatment of ureteropelvic junction obstruction. Laparoscopic pyeloplasty provides a minimally invasive alternative to open pyeloplasty without compromise of treatment success or durability. Even since its introduction by Anderson & Hynes dismembered pyeloplasty is preferred worldwide due to its universal application and excellent success rates. Non dismembered techniques of pyeloplasty are considered useful only in specific conditions. Increased vascularity of the anastomotic segment due to incomplete resection is very helpful for better outcome (b) Methods: The study was conducted in our center from 2011 to 2015. Total of 82 patients underwent lap pyeloplasty during this period and out of this 39 had non dismembered pyeloplasty. The decision to choose the type of pyeloplasty was taken on the bases of presence of crossing vessels on pre-operative imaging studies and intra-operative findings. Data was collected and analyzed and patients were followed up. (c) Results: Median age of our patients at time of surgery was about 25 yrs. The majority of patients were male and left sided disease was more common. There were no complications in early post-operative period. There was only one case of

(a) Introduction and Objective While the method to reconstruct the PUJO or an upper ureteric stricture involves, some form of excision of the ureter and re-anastomosis; the approach to the structures can be changed based on the anatomy of the patient. This video demonstrates the transperitoneal and the retroperitoneal ureterocalicostomy technique and the advantages of each of the retroperitoneal technique. (b) Methods: The transperitoneal technique demonstrated is a four port approach to perform a ureterocolicostomy in a patient with a PUJO obstruction. While the retroperitoneal approach is a three port standard technique demonstrating the same surgery for a lower moiety PUJO obstruction. (c) Results: In both the patients the outcome was satisfactory with reduction in the hydronephrosis post surgery and they continue to remain asymptomatic after stent removal. d) Conclusions: The retroperitoneal technique provides a quick and direct access to the ureter and the kidney. In reconstructive surgery, especially involving the ureter this reduces the time spent in mobilizing the colon and later in having the colon repeatedly falling into the operative area. The ureter and the lower pole of the kidney require very minimal dissection in the retroperitoneal technique and lie in an ergonomic position that
LAPAROSCOPIC REPAIR OF A SIMPLE VVF IN A COMPLEX PATIENT

Introduction: Approach to Vesicovaginal fistula (VVF) is dictated by surgeon’s preference, location and complexity of fistula. Laparoscopic VVF repair adheres to the principles of transabdominal VVF repair, while decreasing morbidity and improving cosmesis. Here is presented a typical supratrigonal VVF post Abdominal hysterectomy, but complex due to previous failed repair and three abdominal surgeries in the past.

Materials and methods: A 63 year old lady with muscle invasive bladder cancer underwent robot assisted radical cystectomy, extended pelvic lymphnode dissection and total intracorporeal ileal conduit construction using marionette technique. Total operative time was 510 minutes. Radical cystectomy with extended pelvic lymphnode dissection took 210 minutes and ileal conduit construction required 300 minutes. Total blood loss was 300 ml. Post operative period was uneventful and total hospital stay was six days. Conclusion: It is possible to perform total intracorporeal ileal conduit using robot assisted laparoscopic technique without much difference in the cost and operative time.
ROBOTIC PARTIAL NEPHRECTOMY IN T1B TUMOUR

**INTRODUCTION** Partial nephrectomy is considered the standard of care for small renal masses. More recently, the role of partial nephrectomy has been expanded to include select patients with T1b renal masses. Retrospective studies have demonstrated the oncologic efficacy of partial nephrectomy in appropriately selected patients with T1b renal tumors achieving the “trifecta outcome” of no perioperative complications, ischemia time of <25 minutes, and negative margins. AIMS AND OBJECTIVES The aim of this video is to demonstrate that the “trifecta outcome” of no perioperative complications, ischemia time of <25 min, and negative margins can be achieved in appropriately selected patients with T1b renal tumors. MATERIALS AND METHODS The patient presented to the outpatient department of urology at our hospital with an incidentally detected right renal mass with no other comorbidities. C.E.C.T KUB demonstrated an enhancing tumor in upper pole of the right kidney measuring 8x6x6 cm. R.E.N.A.L nephrometry score was calculated to be 7a(R-3,E-1,N-2,L-1). Preoperative evaluation was done. His renal function tests were normal. His preoperative haemoglobin was 14. His pre anaesthetic evaluation was done and he was fit to undergo surgery. Informed consent was taken and patient underwent...

Laparoscopic Anderson-Hynes Pyeloplasty in an Ectopic Pelvic Kidney

**Introduction:** Many patients with ectopic kidneys remain often undiagnosed or asymptomatic throughout life. Congential anomalies of urinary tract are often the underlying causes of pathologies. Ectopic pelvic kidneys often present with PUJ obstruction. We report a case of unilateral ectopic pelvic right kidney associated with right descended testis. Case Report: A 29 year old male patient presented with lower abdomen pain for 1 month. Genital examination revealed right descended testis. CT KUB showed ectopic malrotated right kidney with moderate hydronephrosis. DTPA Renogram showed hydronephrotic ectopic right kidney with moderately impaired function due to outflow obstruction. Laparoscopic Right Anderson-Hynes Pyeloplasty with right orchiectomy was done. Laparoscopic pyeloplasty is a safe and feasible option in renal ectopia that offers excellent patient outcomes with low morbidity.