

technique with da Vinci Xi robotic platform of robotic partial nephrectomy (RPN) for challenging renal tumours, including large, hilar and endophytic tumours.

Between July 2016 and March 2019, 24 patients with complex renal mass (based on RENAL nephrometry score of  $\geq 9$  and vascular anatomy) underwent RPN. Patient details were collected for age, gender, American Society of Anesthesiologists score, tumour side, number, size and location. Outcomes measured included operative time, estimated blood loss, warm ischaemia time (WIT), serum creatinine before and after surgery, length of hospital stay, transfusion rate, operative and 30-day complications.

Out of 24, 18 underwent trans-peritoneal RPN and 6 underwent retroperitoneal RPN. Three patients required open conversion after complete hilar dissection. Hilar clamping was utilized with a median warm ischemia time of 30 minutes (IQR 25–45 minutes). Median blood loss was 250 ml (IQR 150–450 ml). Histopathology confirmed clear cell renal cell carcinoma (n = 14), papillary renal cell cancer (4), chromophobe renal cell carcinoma (n = 3), hybrid oncocytic tumour (n = 1), angiomyolipoma (2). All patients had negative surgical margins. Median index tumour size was 4 cm (IQR 3–7 cm). Median hospital stay was 4 days.

Xi robotic platform facilitates tumour resection and renal reconstruction for challenging cases, offering a minimally invasive surgical option for select patients with complex tumours who might otherwise require open surgery. Robotic partial nephrectomy is a safe and feasible approach for select patients with complex renal tumours.

### Robotic nephroureterectomy with bladder cuff excision using Da Vinci Xi: a video presentation of technique

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**Introduction:** Open ureterectomy with excision of bladder cuff has significant wound related morbidity. The laparoscopic approach was first described 1991 (1). Although it improved recovery it is technically demanding. Introduction of the Xi da Vinci robot offered a unique advantage for this procedure, without compromise of oncological outcomes (2). We report our technique and experience with single-docking robotic ureterectomy with bladder cuff excision.

**Methods:** The patients were positioned in lateral decubitus. The four robotic ports were placed in the usual position for nephrectomy, with port 3 sited more infero-medially. The patients underwent radical nephroureterectomy, lymph node dissection and bladder cuff excision, with one patient with previous nephrectomy undergoing a completion ureterectomy with bladder cuff excision. The bladder cuff was excised and two-layer closure of the bladder was performed using a 3/0 V-lock continuous suture. We present details of patient positioning, port placement and technique in our video.

**Results:** Console times ranged from 259 mins to 150 mins. Robotic assistance enabled excellent vision and exposure throughout,

particularly with use of the 4th robotic arm to retract in the pelvis. Robotic intracorporeal suturing was significantly more fluid and precise with mucosa to mucosa suture placement clearly visualised. Estimated blood loss was <100mls. The drain was removed on the second day post operatively with urinary catheter on day three with no cystogram required. The length of stay four days.

**Conclusion:** The Xi system significantly improves nephroureterectomy for surgeon and patient. This system negates the need to undock the robot to change position.

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2. Aboumohamed AA, Krane LS, Hemal AK. Oncologic Outcomes Following Robot-Assisted Laparoscopic Nephroureterectomy with Bladder Cuff Excision for Upper Tract Urothelial Carcinoma. *The Journal of urology*. 2015;194(6):1561–1566.

### Robot assisted urethrolysis and fistula repair post incontinence surgery

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**Aim:** To highlight the benefits of robotic surgery in a case complicated by multiple previous incontinence surgeries.

**Methods:** This is a case of a 35 year old who was referred from another institution. She previously underwent insertion of a (TVT™) for SUI which was complicated by mesh exposure into the vagina, and the vaginal portion of the tape was subsequently removed. She developed de novo OAB symptoms and recurrence of stress incontinence. A second TVT was inserted, this was removed one month later due to severe pain and exposure into the urethra. Three months later, she underwent insertion of a rectus fascia sling, but due to pain, and urinary retention this was also removed.

A EUA, cystoscopy was performed, revealing a hyper-elevated urethra with no mobility. There was a small urethro-vaginal fistula at the distal end of the urethra.

Following discussion, a combined vaginal and robotic approach was proposed.

During surgery the retro-pubic portions of both tapes were identified, and removed. Subsequently the urethra was released bilaterally. Then the fistulous tract was identified and dissected and the defect closed in layers, a martius flap was placed under the midurethra.

**Results:** A catheter was left in situ for 14 days, and post op recovery was uneventful.

**Conclusion:** With the increasing number of complex urogynaecology cases in the clinical setting, the robot-assisted approach allows for meticulous dissection, and excellent access to retropubic space. And at the same time, reducing hospital stay, and quicker recovery.