PE76 Robot assisted cystectomy in the presence of a colostomy

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Introduction & Objectives: The presence of a colostomy can represent a major difficulty for performing robot assisted pelvic surgery by interfering with ports placement. Temporary closure and take-down of the colostomy can be a solution in order to perform the operation.

Materials & Methods: A woman 60 years old with autoimmune neuropathy was referred for a robot assisted total cystectomy. She had a long surgical history with a sleeve gastrectomy and a hysterectomy. The patient had a left terminal colostomy in the left iliac fossa that would interfere with the placement of the left robotic trocars. After discussion, it has been decided to temporary close and takedown the colostomy before placing the trocars in order to be able to perform the operation by robot assisted laparoscopy. Operation took place under general and epidural anesthesia. After patient positioning in a lithotomy position, a skin incision was made around the stoma and the orifice was closed with a pursuing suture of Vicryl® 2/0. The bowel was then mobilized by blunt and sharp dissection from the abdominal wall until completely take down. The stomal orifice was used for the insertion of the first robotic trocar under direct vision and the abdomen inflated to 12 mm Hg. Four trocars were used for the robot on a line at umbilical level and a fifth trocar was inserted in the right iliac fossa for assistance. This was a 15 mm Airseal® trocar. Robot assisted cystectomy was performed following our usual protocol with mobilization of the left ureter under the mesocolon to the right side. An ileal conduit was performed in the right iliac fossa using the terminal ileum and bowel continuity was reestablished by a robotic mechanical laterolateral anastomosis. Specimen was removed through the vagina in an extraction bag. Finally, the left colon was brought back to the abdominal wall and grabbed with a forceps after removing the third robot trocar. The colostomy was sutured again at the initial place with Vicryl 0.

Results: Operation time was 4 hours, peristaltic movement returned at day 2 and patient was allowed to drink and eat. Duration of hospitalization was 4 days.

Conclusions: In the presence of an existing colostomy, temporary closure and takedown of the colostomy seems to be a safe method for addressing pelvic robotic surgery as it offers the possibility to the surgeon for a better trocar positioning and a free surgical field. By this technique a laparoscopic robot assisted pelvic surgery is feasible even in the presence of a colostomy in the site of trocar placement and thus avoiding the need of an open surgery. It is thus considered to be a less traumatic operative method, as due to zooming in the picture there is greater accuracy in handling the tissue, and blood loss is minimal. This approach permits the patient to benefit from a minimally invasive technique.