PE87 Evaluation of perioperative outcomes from a case series of robotic treatment of colo-vesical fistula without bowel resection

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Introduction & Objectives: The standard surgical treatment of colovesical fistula (CVF) includes resection of the offending bowel segment with contextual or subsequent anastomosis and is usually performed through an open approach. Recently, minimally invasive techniques are gaining acceptance in the treatment of diverticular fistulas because they allow to reduce overall morbidity and to achieve better postoperative outcomes and faster recovery with respect to open surgery. Nevertheless, mortality and morbidity rates remain relevant due to colic resection, adhesions, paracolic abscesses, colon and mesocolon shortening and colic parietal thickening related to diverticulitis. In all cases we performed a robotic conservative technique including simple fistulectomy and suture of the sigmoid parietal defect, avoiding colic resection. The aim of the study was to evaluate the feasibility and safety of robotic conservative surgery for colo-vesical fistula through retrospective analysis of perioperative outcomes from a case series of consecutive robotic conservative treatments.

Materials & Methods: Between July 2016 to December 2018, at our institution robotic conservative treatment was performed in 7 consecutive unselected patients with CVF. A prospective database was created and it included demographic and perioperative data, that was retrospectively evaluated. Peri-operative complications were assessed according to Clavien-Dindo classification.

Results: Demographic and perioperative data are shown in Table 1. In all cases, isolation and resection of the fistulous tract were performed and the sigmoid wall was closed by stapler without performing any bowel resection. A temporary diversion (loop ileostomy) was carried out only in one patient because of extended diverticular disease. No conversion to open surgery was necessary. Urinary catheter was removed 7 days after surgery. No intra-operative complications occurred and no blood transfusions were needed. Two grade II complications occurred: Postoperative urinary tract infection and transient ileus, that were treated by antibiotic therapy the first one, fasting and nasogastric tube for three days the second one. There was no case of fistula recurrence.

	ROBOTIC CONSERVATIVE SURGERY
CASES	7
MEAN AGE (range)	55 years (42-83)
MEAN OPERATIVE TIME (range)	108 min (73-160)
MEAN ESTIMATED BLOOD LOSS (range)	47 ml (20-100)
TIME TO BOWEL MOVEMENT (range)	64 hours (24-120)
MEAN HOSPITAL STAY (range)	7.3 days (5-10)
MEAN VAS SCORE (range)	1.7 (1-3)
PERIOPERATIVE COMPLICATION	2
RECURRENCE	NONE
MEDIAN FOLLOW-UP (range)	13 months (4-19)

Table 1: the table shows the demographic and peri-operative data.

Conclusions: Robotic conservative treatment of CVF seems to be a safe and feasible technique. However, larger prospective studies are needed to confirm these preliminary results.