

VIDEO ABSTRACT

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Robotic intracorporeal studer pouch construction after genitalia preserving female cystectomy

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Citation: Alkan E, Canda AE, Turan M, Yilmaz M, Ozkanli AO, Balba MD. Robotic intracorporeal studer pouch construction after genitalia preserving female cystectomy. Cent European J Urol. 2016; 69: 235-236.

Article history

Submitted: July 31, 2015

Accepted: Feb. 13, 2016

Published online: April 6, 2016

Key Words: intracorporeal neobladder <> female <> robotics

In this video, our technique of robotic intracorporeal Studer pouch construction, specifically emphasizing our suturing and stenting techniques, is presented. A 63 year-old female patient with muscle invasive bladder cancer was referred to our hospital for robotic radical cystectomy and intracorporeal Studer-pouch construction. Her pathological stage prior to radical cystectomy was T1GIII and in the endoscopic examination, the tumor was found to have spread all over the bladder mucosa. Her past medical history revealed a laparoscopic cholecystectomy 20 years ago and a cesarean section 30 years ago.

Surgical Technique: Having completed the genitalia preserving female cystectomy and extended pelvic lymphadenectomy, intracorporeal neobladder construction was started. Identifying the ileocecal junction, stay sutures were placed on the antimesenteric border of the ileum 20 cm apart. The most dependent region of the ileal segment to be used for the pouch, approximately 35 cm from the ileocecal junction, was determined by bringing the ileal wall down to the membranous urethra. A 2 cm opening was made at this site and the membranous urethra was sutured to the ileum at this opening. Intestinal

staplers were applied at 20 cm and 50 cm from the ileocecal junction. Sparing the most proximal 10 cm of the ileum as an afferent loop, the ileal segment was opened on its antimesenteric border. The posterior wall of the pouch was brought together with interrupted sutures placed 5 cm apart and a running 3/0 monocryl. Running suturing was performed by passing 3–5 throws forming loose loops before pulling it up and tightening the suture line. The foley catheter was exchanged with a nelatone tube. The anterior wall of the pouch was folded downwards from its middle and a transverse anastomosis was accomplished using a running 3/0 monocryl. A Wallace type ureteroureterostomy was done between the spatulated ends of the ureters. A silk tie was pulled up bringing the nelatone tube through the opening at the level of ureterointestinal anastomosis. Two DJS (double J stent) were introduced into the nelatone outside the body and guided to both ureters. Additionally, another guide wire was sent and the nelatone tube was removed. Finally a 20F Foley catheter with a slit at its tip was inserted into the pouch over this guide wire after the distal ends of the DJS were tied together and to the Foley

catheter outside. Tightening the suture line after passing 4–5 throws so that the string makes big loops prevents the need of laparoscopic hooks and shortens the procedure. Internalizing DJS prevents bridging of the intestinal elements around them intraabdominally outside the pouch. It may also reduce infectious complications and decrease the amount of mucus clogs due to the diversion of produced urine into the pouch which results in low pressure, continuous irrigation with patients own urine.

The patient has full daytime continence at the 3rd postoperative month. CT shows a near natural look-

ing neobladder and well preserved internal genitalia. In conclusion, our robotic suturing and internal stenting techniques reported for the first time in English literature are useful adjuncts to a complicated robotic surgical procedure which we believe decreases perioperative complication rates.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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