

VIDEO ABSTRACT

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Robotic genitalia sparing female cystectomy

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This article presents our surgical technique on robotic cystectomy preserving female genitalia. A 59 year-old female patient with muscle invasive bladder cancer was referred to our hospital for robotic radical cystectomy and intracorporeal Studer-pouch construction. An incomplete trans urethral resection of the bladder cancer was performed 2 months earlier at a peripheral hospital and pathological examination revealed muscle invasive, high-grade papillary urothelial carcinoma (T2GIII). She had undergone two open abdominal surgeries (appendectomy and cesarean section) 30 and 35 years previously. Laboratory tests including blood urea nitrogen, serum creatinine, hemogram, ALT, and AST were within normal limits. A CT scan of the abdomen and pelvis revealed several masses within the bladder, measuring up to 1 cm in greatest dimension. However, perivesical fatty tissue and upper urinary tract were normal in appearance.

Surgical Technique: Ureters were dissected in the retroperitoneal area down to the broad ligament where the most distal parts are reached. Then, ureters were double clipped and distal ends were sent for analysis. On the anterior abdominal wall the parietal peritoneum lateral to the medial um-

bilical ligament was opened and the Retzius space was entered, exposing endopelvic fascia. At this stage, the median umbilical ligament was kept intact to suspend the bladder in order to facilitate the posterior dissection. Peritoneum was incised posterior to the bladder where it folds over to the uterus. Adhesions from previous cesarean section were taken down. As downward dissection continued, the vesico-vaginal space was entered. Dissection continued toward to the peritoneum, posterior bladder pedicles were developed, and cut. Distal ureteral stumps were dissected off of the anterior vaginal wall to be included in the surgical specimen. Having completed the posterior dissection, the urachus was severed at the level of umbilicus to expose the area anterior to the bladder. Urethra and bladder neck were identified and endopelvic fascia on each side of the urethra were opened. Majority of proximal urethra was dissected from the anterior vaginal wall without disturbing lateral paravaginal tissues. Bladder neck was sutured and occluded to prevent spillage of urine to the peritoneal cavity at the time of division. Urethra was divided; its most proximal margin was excised and sent for frozen section analysis. Lastly, lateral bladder pedicles were taken down

and the specimen was entrapped in a bag. Surgery lasted for about 2 hours. There was minimal bleeding less than 100 ml. No major perioperative complications were seen.

In conclusion, robotic genitalia preserving female cystectomy is surgically feasible without significant bleeding and major surgical complications. Paravaginal tissues thought to be crucial for external

sphincteric function are left untouched with this technique.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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