

**CONCLUSIONS:** At selected institutions robotic surgery for selected level I and II caval thrombi is feasible. Further, clinical experience is necessary to determine the appropriate place of robotic surgery in managing these complex patients with caval involvement.

**SOURCE OF FUNDING:** None

#### VP13-09 POSTERIOR APPROACH TO ROBOTIC SIMPLE PROSTATECTOMY

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**INTRODUCTION AND OBJECTIVES:** This video describes our novel technique for performing robotic simple prostatectomy (RSP) for benign prostatic hyperplasia (BPH).

**METHODS:** From May 2013 through February 2014, a single surgeon (DDE) performed RSP on 14 patients with symptomatic BPH using our posterior approach technique. This technique includes a posterior cystostomy, lateral retraction of the bladder via extracorporeal sutures and exclusion of the prostatic defect. The posterior cystostomy offers easy visualization of the enlarged gland without mobilization of the bladder. Closure of the prostatic defect is achieved by anastomosing the urethra to the bladder neck after adenoma removal, eliminating the need for post-operative bladder irrigation.

**RESULTS:** The mean patient age was 68 years (60–79) and mean prostatic volume was 133 cc via transrectal ultrasound (83–200). Mean pre-operative IPSS score and SHIM score were 21.6 (15–28) and 12 (1–24) respectively. Average console time was 155 min (98–297) and average EBL was 282 mL (range 50–1000). The mean weight of removed adenoma was 88.9 grams (34–153). The average length of stay was 1.2 days (range 1–3). There were no intraoperative or post-operative urologic complications and pathology confirmed BPH in all cases. Post-operatively, IPSS scores were significantly improved (Mean 4.2, range 0–12,  $p < 0.001$ ). There were no adverse effects on the post-operative SHIM score (Mean 10.6,  $p = 0.60$ ).

**CONCLUSIONS:** Our limited experience with this novel approach to RSP has been shown to be technically feasible and safe. Patients who underwent RSP had a short hospital stay with excellent post-operative improvement in lower urinary tract symptoms without compromising erectile function.

**SOURCE OF FUNDING:** None

#### VP13-10 OMITTING CORTICAL RENORRHAPHY DURING PARTIAL NEPHRECTOMY

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**INTRODUCTION AND OBJECTIVES:** Little is known about the effects of reconstruction during partial nephrectomy on postoperative renal function. Our objective is to assess the feasibility of omitting cortical renorrhaphy during partial nephrectomy.

**METHODS:** In 2013 we began routinely omitting cortical renorrhaphy during robotic partial nephrectomy for renal masses. A running base layer stitch is meticulously performed after resection with additional figure-of-eight stitches as needed after unclamping the renal hilum. Operative videos are presented for a large tumor in a solitary kidney and an endophytic tumor in a

non-solitary kidney. Omission of the cortical renorrhaphy layer is detailed with tips on hemostasis and urine leak prevention.

**RESULTS:** Both cases were performed without any intra-operative or postoperative complications. The solitary kidney experienced minimal postoperative volume loss at 4-months (13%), and the GFR rebounded at 6-months back to 41 from a baseline of 42. Renal function data for the second case is pending follow-up.

**CONCLUSIONS:** Cortical renorrhaphy can be safely omitted when using a meticulously placed base layer renorrhaphy. This may be of particular benefit when treating a renal mass in a solitary kidney or near the renal hilum.

**SOURCE OF FUNDING:** None

#### VP13-11 NOVEL USE OF TACHOSIL IN HAEMOSTASIS IN NERVE-SPARING ROBOT-ASSISTED LAPAROSCOPIC RADICAL PROSTATECTOMY

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**INTRODUCTION AND OBJECTIVES:** Various nerve-sparing techniques are used in robot-assisted laparoscopic radical prostatectomy (RaLRP), with the aim to maximise postoperative erectile function and continence without compromising oncological control. Apart from interfascial dissection and preservation of neuromuscular bundles, avoidance of traction and electrocauterisation and are equally important, which could lead to suboptimal haemostasis. Recently, a novel fibrin sealant patch has been introduced (Tachosil<sup>®</sup>, Takeda Pharmaceuticals GmbH) to aid haemostasis. Herein we describe our initial experience of using this patch in haemostasis in nerve-sparing RaLRP.

**METHODS:** A 72 years old man complained of lower urinary tract symptoms. Prostate specific antigen (PSA) was elevated at 5.8 ng/ml. Transrectal ultrasound guided 12-core biopsies revealed adenocarcinoma of Gleason score 3+3 in one core. Transperitoneal RaLRP was performed with interfascial dissection and preservation of the right neuromuscular bundle (NVB). After removal of the prostate, a piece of fibrin sealant patch was placed near to the right NVB for haemostasis. The patch would stay attached to the tissue after activation. No additional haemostatic measure was required thereafter.

**RESULTS:** Operative time was 6.5 hours and estimated blood loss was 200 ml. Patient recovered uneventfully from the operation. Pathology showed pT2c adenocarcinoma of Gleason score 3+3 and a tertiary grade of 4. Three months after operation the PSA level was undetectable. He has no urinary incontinence and has not attempted any sexual activities yet.

**CONCLUSIONS:** The fibrin sealant patch aid effective haemostasis. With more operative experiences, this could be a useful device in nerve-sparing surgery in future.

**SOURCE OF FUNDING:** No funding received

#### VP13-12 ROBOTIC NEPHROURETERECTOMY WITH BLADDER CUFF EXCISION IN THE MORBIDLY OBESE PATIENT: TIPS FOR POSITIONING, PORT PLACEMENT AND DOCKING

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