

V-05.10

Urethral hemangioma-laser treatment: point of technique

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Introduction: Urethral hemangiomas are uncommon and sometimes bleeding from this can be brisk and troublesome.

Methods: A 71-year-old lady with anemia secondary to bleeding from recurrent urethral hemangioma was treated with Holmium laser therapy.

Results: Treatment resulted in cessation of bleeding and eradication of the hemangioma.

Conclusion: Holmium laser therapy was effective in this case and should be considered in the management of bleeding and difficult urethral hemangiomas.

V-05.11

Penile carcinoma: organ sparing surgery

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Introduction: Penile carcinoma is uncommon, but when diagnosed, it is psychologically devastating to the patient and often presents a challenge to the urologist. We present organ-sparing surgery based on penile disassembly technique in 38 years old patient with penile carcinoma.

Methods: Biopsy previously done confirms stage one squamous cell carcinoma. Penile disassembly starts with urethral mobilization. The urethra is lifted together with Bucks fascia. Dorsally neurovascular bundle is dissected by blunt and sharp maneuvers. Glans with urethra ventrally and neurovascular bundle dorsally is completely separated from corpora cavernosa. Neurovascular bundle is divided 2cm under the glans cap. Glans is removed after division of the urethra. Biopsy of the margins confirmed that the resection has been adequate. Urethra is spatulated 4cm in length and fixed to the corpora cavernosa. Spatulated part is used for creation of neoglans. At proximal level, each corpora cavernosa is fixed to the skin using U-shaped suture in order to avoid postoperative retraction of the penis. Reconstruction of the penile skin is performed as in circumcision.

Results: Six months after surgery good appearance is achieved. Erectile function is completely preserved.

Conclusion: Organ sparing surgery is the method of choice in the treatment of low-grade penile carcinoma. It is most impor-

tant for young patients to retain a functioning penis.

V-06: Prostate Cancer/BPO
Wednesday, November 15
10:15-12:15

V-06.01

Extraperitoneal Laparoscopic Radical Prostatectomy (ELRP)Peña J, Gonzalez J, Hannaoui N, Vicente E, Garcia D, Abad C, Prera A, Prats J
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Introduction: We present a video of our initial experience with the practice of the laparoscopic radical prostatectomy through an extraperitoneal access. Surgical steps are shown and commented.

Methods: From January 05 to February 06 we have started 36 ELRP in our institution. Two of them were performed with the help of a master. We followed the Brussels technique but without preservation of the neuron vascular bundles.

Results: Of the 34 cases performed without external aid, 23 were completed and 11 converted to open surgery. (23 /34, 68%). While of the first 10 we just completed 2, of the last twenty we finished 19 by laparoscopy. Surgical time consumption has diminished from 475 in the first case to 200 minutes in the last one. Only 1 of 23 required blood transfusion. Mean hospitalization rate has been 4 days. Conversion to open surgery during extraperitoneal laparoscopic procedure is not very difficult but previous surgical experience is required.

Conclusion: ELRP is feasible in an institution like ours (600 beds) but is necessary a team with previous experience in laparoscopic surgery and the aim of invest a big effort, specially in what a operating room time consumption respects.

V-06.02

Laparoscopic radical cystoprostatic adenectomy

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Introduction: We hereby present a new laparoscopic prostate-preserving cystectomy technique that aims at reducing sexual dysfunction and urinary incontinence in comparison with the conventional technique of laparoscopic radical cystoprostaticectomy.

Methods: We performed a laparoscopic cystoprostatic adenectomy with ileal neobladder. The plane between the rectum and the bladder was developed. Then, the space of Retzius was entered, the endopelvic fascia was not opened, and the bladder neck was exposed. The lateral bladder pedicles were controlled using bipolar electrocautery. A transverse incision was made on the prostatic capsule near the bladder neck and was deepened to reach the prostatic adenoma. The adenoma was then completely separated from the capsule. The Foley catheter was cut in the urethra, and the distal part was pushed into the bladder. Incision of the prostatic capsule was completed after enucleating the adenoma. The seminal vesicles were preserved.

Results: The operative duration was 180 minutes. Estimated blood loss was 250 ml. The patient was discharged on the seventh postoperative day. The ureteral catheters and the Foley catheter were removed 14 and 20 days after the operation, respectively. No intra- or postoperative complications occurred. The patient was completely potent and continent 1month after the operation.

Conclusion: It seems, with our technique of complete removal of the bladder neck and prostatic adenoma, the risks of positive surgical margins and tumor spillage were reduced significantly. We propose this technique in patients with invasive bladder cancer.

V-06.03

Nerve sparing robotic da Vinci radical prostatectomy

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Introduction: The incorporation of new technologies, like robotics, puts urologic surgery at a level, unimagined before.

Material and Methods: We present a demonstrative video of a robotic nerve sparing radical prostatectomy performed by a surgeon without previous laparoscopic experience on a 57 year old patient (T1c, preoperative PSA 5.4 ng/ml, positive needle biopsy in the right lobe, Gleason score 3+3), being the ninth case since the start of advanced robotics in our centre. We show the position of the 6 trocars used by the robot and the assistant, the installation of the robot with connection of the trocars, the ergonomically seated position of the surgeon at the console, the complete control of the master handles over the movements of the robotic arms, the movements of the min-