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We began with cystourethroscopy. The 22Fr rigid cystoscope was advanced into the bladder via urethra with copious lubrication and sterile irrigation running. The urethra was normal. There was a left ureteral stent eminating from the ureteral orifice without encrustation. It was grasped and brought to the urethral meatus. A sensor wire was passed through the ureteral stent into the left kidney. The ureteral stent was removed. We then advanced a flexible ureteroscope over the sensor wire into the left kidney and removed the sensor wire. We advanced a Foley catheter adjacent to the flexible ureteroscope and placed 10 mL of sterile water in the catheter balloon.

We began the robotic portion of the procedure by achieving pneumoperitoneum using standard veress technique in the supraumbilical midline abdomen superior to the umbilicus. The abdomen was entered with a 5mm visiport. Abdominal inspection using the robotic camera was negative for any intraabdominal injuries. There were no intraabdominal adhesions.  All subsequent ports were placed under direct vision without injuries or complications.  These ports included four total 8mm robotic ports in the midline spaced about 7-8cm away from each other, as well as a 12 mm assistant port triangulating two 8 mm robotic port sites that was placed just right of midline. The 5 mm Visiport was replaced with an 8 mm robotic port. The patient was rotated with the left side up and the robot was brought in and docked.

We turned our attention to the left lateral abdominal wall where the white line of Toldt was noted. The large colon was dropped medially after incising the white line of Toldt. We identified the proximal ureter containing the ureteroscope using Firefly technology. We were able to dissect circumferentially around the proximal ureter without entry into the ureter. We then circumferentially dissected the ureter distally toward the iliac vessels. We had to ligate the gonadal vein to perform our dissection, which was done using bipolar electrocautery. There was significant fibrosis surrounding the ureter. We dissected distally using the ureteroscope to help guide the anatomy of the ureter. Our dissection was taken distally to the common iliac vessels where much less fibrosis was noted. There was no ureteral injury noted throughout the entire dissection. An omental flap was then dissected off of the small bowel, brought underneath the right ureter to create an omental flap and intraperitonealize the right ureter. Using 2-0 Vicryl the omentum was tacked to the right abdominal wall and then folded over the right ureter using interrupted sutures.

The robot was undocked. A sensor wire was advanced through the flexible ureteroscope. A 6 French x 24cm double-J ureteral stent without dangler was advanced over the sensor wire with the assistance of a stent pusher without difficulty. The 12 mm assistant port was closed at the level of the fascia with a Weck fascial closure device. All skin incisions were closed with 4-0 Monocryl and skin glue. The Foley catheter was left in place. The patient was woken up from anesthesia and taken to the recovery room in good condition.  All surgical counts were correct x2.