VIDEOS WITH PRESENTATION IN ROOM

NOVEMBER 28, SUNDAY | 09:00-10:00h

V 01

ROBOT-ASSISTED RADICAL NEPHROURETERECTOMY WITH EXTRAVESICAL EXCISION OF THE INTRAMURAL SEGMENT OF THE URETER

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Introduction and objectives: Radical nephroureterectomy with bladder cuff excision (BCE) is the gold standard treatment for high risk upper tract urothelial carcinoma. BCE is an important step due to high risk of local recurrence. The removal of the bladder cuff can be performed by an intravesical, extravesical or transurethral incision, either by open, laparoscopic or endoscopic access. However, the optimal technique is yet to be defined, especially in the setting of minimally invasive approaches. We present a robot-assisted radical nephroureterectomy (RARNU) with extravesical excision of the intramural segment of the ureter and ureteral meatus without opening of the bladder mucosa with the aim of minimizing the risk of tumor cell spillage.

Material and methods: An 80 years old male patient was referenced with a 13mm contrast-enhancing incidental solid endoluminal mass on the left renal pelvis. Staging showed a cN0M0 tumor. Cystoscopy showed no suspicious bladder lesions and a bulky prostate middle lobe with protrusion to the bladder. Due to proximal location of the urothelial tumor and the extensive mucosal oedema and mucosal venous ectasia in the trigone, the patient was proposed for a RARNU with extravesical BCE.

Results: The patient was positioned in a left lateral decubitus and four 8mm ports were placed in the midclavicular line in a slightly oblique fashion with the lower port more medial. This obviated the need for dual docking since it allowed a better distal ureter access. The nephrectomy was performed first. Three renal veins and one renal artery were isolated and clipped. Ureter dissection proceeded distally until the identification of the ureterovesical junction. The intramural tunnel dissection was carried through the Waldeyer's sheath while countertraction with a fenestrated grasper was applied. The distal ureter was ligated with a clip to isolate the upper tract urine. The bladder mucosa dome was exposed with extravesical identification of the ureteral meatus and a cerclage suture was placed while around the latter. A second transfixing suture was placed to reinforce the bladder mucosa closure distal to the meatus. The ureter was transected and the specimen was extracted en bloc with an endobag. The detrusor and adventitia were closed with a multifilament absorbable running suture. A Blake drain was placed.

Conclusions: The surgical approach to BCE is yet to be standardized. A totally extravesical complete BCE is possible with RARNU, allowing zero urine spillage and complete control

of the dissection limits. Robotic assistance overcomes the technical limitation of this extravesical approach which is technically challenging due to the reduced work space. Robotic surgery also allows better vision, and instrument stability and precision. This technique permits an en bloc excision of the specimen without urine extravasation, less morbidity, and without compromising oncological outcomes.

V 02

NEOBEXIGA DE "BORDÉUS" TOTALMENTE INTRACORPÓREA VIA LAPAROSCÓPICA

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João Varregoso; Fernando Ferrito
Hospital Prof. Doutor Fernando Fonseca, EPE

Introdução: A neoplasia da bexiga é a décima neoplasia mais diagnosticada no mundo, sendo a decima terceira causa de mortalidade oncológica mundialmente. O tratamento da neoplasia da bexiga musculo-invasiva tem como gold-standard a cistectomia radical com linfadenectomia pélvica e a realização de uma derivação urinária. Globalmente as derivações urinárias dividem-se em derivações urinárias cutâneas, incluindo nesta o conduto ileal, derivações urinárias uretrais, chamadas habitualmente de neobexigas e derivações urinárias colónicas.

A escolha da derivação urinária utilizada tem uma grande importância para o doente pois está associada a complicações que podem ser graves, nomeadamente metabólicas e infeciosas, entre outras, a necessidade de cuidados determinados pós-operatórios, tais como auto-algaliação e a importantes perturbações da imagem corporal. Tradicionalmente as derivações urinárias continentes estão associadas a um nível superior de complicações Com o advento da cirurgia minimamente invasiva, com a laparoscopia e laparoscópica assistida por robot, foram realizadas as mesmas derivações que pela via aberta com o intuito de diminuir a morbilidade associada a esta via, com menos dor, menos hemorragia e mantendo os resultados funcionais. Contudo a nível de tempo operatório este poderá ser superior recorrendo a este tipo de cirurgia.

Objetivos: Apresentação de um vídeo da realização de uma neobexiga de "Bordéus" totalmente intracorpórea via laparoscópica realizada na nossa instituição.

Material e métodos: Este vídeo foi gravado utilizando abordagem laparoscópica com visão 2D.

Resultados: Doente do sexo masculino, 75 anos, sem antecedentes pessoais relevantes, foi encaminhado para a consulta de Urologia por hematúria e por lesão vesical suspeita com 4 cm na parede lateral esquerda. Foi submetido a RTU-V que identificou tumor urotelial de alto grau musculo-invasivo – pT2. Nos exames de estadiamento com TC, não havia evidência de envolvimento metastático à distância nem envolvimento ganglionar.

Foram abordadas as opções terapêuticas e optou por cistectomia radical com linfadenectomia com neobexiga via laparoscópica, que decorreu sem intercorrências.

O pós-operatório foi na Unidade de cuidados intensivos e teve complicações. A destacar a extrusão da algália, com necessidade de recolocação de algália com cistoscopia flexível, no qual se identificou falso trajecto de provável etiologia traumática na face posterior da anastomose uretro-ileal. Por manter leak urinário mesmo após recolocação da algália, houve necessidade de colocar nefrostomias bilaterais. Após 3 semanas foram removidas, com resolução do leak urinário.

Discussão/Conclusões: A neobexiga totalmente intracorpórea via laparoscópica é uma opção válida e fazível por esta via. Contudo tal

como as neobexigas realizadas por via aberta, as complicações pós-operatórias não são negligenciáveis e a sua correta abordagem é muito importante na morbilidade e mortalidade associadas ao procedimento.

V 03

LAPAROSCOPIC RADICAL NEPHRECTOMY WITH INFERIOR VENA CAVA THROMBECTOMY

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Introduction and objective: Renal cell carcinoma (RCC) presents with inferior vena cava (IVC) thrombus in 4-10% of the patients. Radical nephrectomy with IVC thrombectomy is the mainstay of treatment.1 Our objective is to show the first case laparoscopic management of these patients in our hospital.

Material and methods: In this educational video we present the case of 69-year-old male with a diagnosis of renal cell carcinoma with a tumor thrombus in one renal vein and protruding to the inferior vena cava. We describe our surgical technique of laparoscopic radical right nephrectomy with IVC thrombectomy.

Results: This patient was a man with 69 years and various comorbidities: arterial hypertension, diabetes mellitus, benign prostatic hyperplasia, a history of gastric ulcer and recent COVID-19. He was admitted to our Urology department due to persistent fever with the diagnosis of a prostatic abscess. During its workup, a right renal mass was incidentally identified in the computed tomography (CT) scans. A contrasted CT was performed and revealed "a nodular lesion in the posterior aspect of the right kidney with at least 4x2. 5cm suggestive of renal neoplasm, with some calcifications. There is a large thrombus in the renal vein that prolongs to the inferior vena cava (IVC), admittedly a tumoral tissue thrombus because of its contrast enhancement. There is no complete occlusion of the IVC". The staging exams showed no enlarged regional lymph nodes or distant metastasis. We performed a laparoscopic radical nephrectomy with inferior vena cava thrombectomy as reported in the literature1. Some of the critical steps of the surgery are the liver retraction and Kocher maneuver, to facilitate the optimal exposure of the IVC. Early clamping of the renal artery is essential to prevent bleeding. The IVC was clamped using vascular loops and hem-o-locks. After its clamping, the renal vein was sectioned close to the IVC, revealing a protruding tumor thrombus. The thrombus was completely excised with the renal vein and sent to pathology with the nephrectomy specimen. The pathology report revealed a renal cell carcinoma (clear cell RCC, G2), with a maximum length of 6.5cm, invasion of the renal sinus and a tumor thrombus in the renal vein - pT3a G2 Nx. The thrombus extremity, however, was inside the IVC (level I tumor thrombus). The patient was discharged after 5 days without complications and remains under surveillance with no evidence of recurrence.

Discussion: Laparoscopic radical nephrectomy with IVC thrombectomy is a challenging procedure but it has all the advantages of a minimally invasive surgery. Cases like the one we described, a level I tumor thrombus not adherent to the IVC walls, are probably the main indication for this technique.

V 04

LAPAROSCOPIC BILATERAL RETROPERITONEAL LYMPH NODE DISSECTION

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Introduction: Retroperitoneal lymph node dissection is a complex surgery indicated in some cases of testicular cancer, namely in patients with non-seminomatous germ cell tumours who have residual retroperitoneal masses after chemotherapy. The laparoscopic technique, initially described in 1992, is particularly challenging. However, it offers advantages compared to the open approach, since it is less invasive and is associated with reduced overall complication rates and shorter length of hospital stay with equal cancer control results.
Objectives: In this video, we report a case of a laparoscopic bilateral retroperitoneal lymph node dissection performed in a 21-year-old male with residual retroperitoneal masses after chemotherapy for mixed germ cell tumour.
Materials and methods: The patient was placed in supine position with moderate Trendelenburg and a urethral catheter and a nasogastric tube were placed. The first infra-umbilical 11mm port was introduced under direct visualization. Thereafter, two 5mm ports were placed in each side of the abdomen.
Results: Firstly, the ceacum was identified and the right colon, small intestine and duodenum were mobilized. Sutures were used to tack the incised peritoneal edge of the intestine to the abdominal wall. The retroperitoneum was then exposed and the lymph node dissection initiated. The bilateral lymph node dissection template was bordered by the ureters laterally, the renal vessels superiorly and the common iliac arteries inferiorly. Initially, the paracaval space was dissected, followed by the paraaortic and interaortocaval spaces. The left colon was also mobilized. After that, the lymph nodes were removed in the same sequence, with ligation of the left gonadal vein with hem-o-lok.
Patient was discharged on postoperative day 14. Histology report showed 31 lymph nodes without metastases and with alterations compatible with previous chemotherapy.
Conclusion: Laparoscopy is an effective approach for retroperitoneal lymph node dissection, with similar oncological outcomes and inferior patient burden compared to the open approach.

V 05

COMPLETE STAGHORN CALCULUS: ONE STAGE PERCUTANEOUS NEPHROLITHOTOMY WITH TRILOGY® DEVICE AS THE ENERGY SOURCE

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Introduction and objectives: Staghorn calculi remain a challenge. Percutaneous nephrolithotomy (PCNL) is the preferred treatment for the management of large or complex calculi. Clearance of stone with PCNL requires some form of energy source to break the stone. The Trilogy is a dual-energy lithotripter, using electromagnetic and ultrasonic energy for stone fragmentation with suction which facilitates the evacuation of stone fragments.
We present a clinical case where we used Trilogy® as the energy source for the treatment of a complete staghorn calculus in a one stage procedure.
Materials and methods: A 76 years old female patient presents with an incidental staghorn calculus on a thoracic CT.
The uro-CT confirmed a complete staghorn calculus and showed a reduction in renal parenchymal thickness. The estimated stone

volume was 80.322cm3.
The Tc-99m DTPA renal scintigraphy revealed a left kidney function of 42% (glomerular filtration rate of 32ml/min) and a right kidney function of 58% (glomerular filtration rate of 44ml/min).
The patient was proposed for a percutaneous nephrolithotomy.
Results: The procedure was done in Galdakao position. Upper, middle and lower calyces were punctured under fluoroscopic guidance and a hydrophilic angled guide wire was passed through the access needle.
Initialy, upper and lower access tracts were dilated and a 17.5F sheath was placed. A 12F nephroscope was used and fragmentation of the most distal portion of the calculus was performed with pneumatic lithotripter (3F probe). The stone fragments were removed through vacuum cleaner effect. Subsequently, a balloon dilator was placed and was inflated to 18 atmospheres. An Amplatz 24F working sheath was secured. A 22F nephroscope was used and stone fragmentation was performed with Trilogy device (10.5F probe).
The stone fragmentation through the middle access tract was done with just the pneumatic lithotripter. A residual stone in the anterior middle calyx was left in view of the prolonged procedure time.
A 6Fr double-J stent was placed retrogradely. A 12F malecot nephrostomy catheter was placed through the middle calyceal access.
The procedure lasted 210 minutes.
Proteus mirabilis was isolated in the biofilm and stone culture.
The 12F Malecot nephrostomy catheter was removed on the 4th post-operative day. The patient was discharged on the 6th post-operative day with stable renal function and hemoglobin levels. The 6F double-J stent was removed on the 26th post-operative day.
Stone analysis revealed 75% calcium phosphate and 25% magnesium ammonium phosphate.
The patient is currently asymptomatic.
Conclusion: The trifecta of ultrasonic and electromagnetic impactor energy with suction is efficient and safe in clearing larger and complex stone bulk in a one stage procedure, that seems impractical with the stand-alone energy sources available

V 06

NEFROURETERECTOMIA TOTAL LAPAROSCÓPICA 3D EM DOENTE COM URETEROILEOSTOMIA CUTÂNEA (BRICKER)

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Introdução: O aparelho urinário superior é o local mais comum de recorrência tardia após cistectomia radical, sendo que os doentes com tumores não musculo-invasivos da bexiga tem o dobro do risco de desenvolver recorrências no urotélio alto comparativamente a doentes com tumores musculo-invasivos.
A nefroureterectomia radical é considerada a cirurgia standard em doente com tumores primários e localizados do urotélio alto. No entanto, não existem orientações claras sobre o tratamento das recorrências no aparelho urinário superior após tratamento de tumores da bexiga.
Objetivo: Apresentar um vídeo de uma nefroureterectomia total laparoscópica por recorrência no urotélio alto de neoplasia urotelial, em doente já previamente submetido a cistectomia radical com ureteroileostomia tipo Bricker.
Material e métodos: Vídeo de nefroureterectomia direita laparoscópica em doente portador de ureteroileostomia cutânea.
Caso clínico: Doente com 71 anos, sexo masculino com antecedentes de adenocarcinoma

da próstata, submetido a prostatectomia radical com linfadenectomia pélvica bilateral e radioterapia adjuvante em 2015. Em 2019, foi submetido a resseção transuretral da bexiga por pT1 de alto grau multifocal com carcinoma in situ. Apresentava ainda lesões compatíveis com cistite rádica e uma bexiga de pequena capacidade e elevadas pressões que condicionavam ureterohidronefrose bilateral com impacto na função renal, para além de episódios recorrentes de hematúria. Foi, por isso, submetido a Cistectomia radical com ureteroileostomia cutânea. Em UroTC de seguimento 12 meses após cistectomia foi detetada uma massa de tecidos moles no rim direito com cerca de 27mm, com efeito de realce após contraste e restrição à difusão compatível com suspeita de malignidade, localizada no grupo calicial médio.
Foi submetido a nefroureterectomia total direita laparoscópica com laqueação do ureter terminal a nível da anastomose uretero-ileal com recurso ao sistema de agrafagem Signia. O tempo de cirurgia foi de 75 minutos e a hemorragia intra-operatória foi de 50mL. O pós-operatório decorreu sem intercorrências e o doente teve alta ao 3º dia. A histologia revelou a presença carcinoma urotelial papilar de alto grau multifocal, sem invasão do tecido conjuntivo subepitelial, da camada muscular ou da gordura, margens cirúrgicas negativas.
Após 12 meses de seguimento mantém-se sem evidências de recidiva.
Discussão/Conclusão: Apesar do urotélio alto se tratar de um local comum de recorrência em doentes submetidos a terapêutica local de carcinoma da bexiga, não existem recomendações claras sobre o que fazer nestes casos. Diversos estudos demonstram a nefroureterectomia laparoscópica com resultados a nível oncológico não inferiores à cirurgia aberta, com vantagens na recuperação pós-operatória.
A utilização do sistema de agrafagem Signia permite realizar a cirurgia de forma rápida e segura podendo o equipamento ser utilizado tanto na laqueação do pedículo renal como na laqueação do ureter na sua anastomose uretero-ileal.

V 07

LAPAROSCOPIC TREATMENT OF ENTERO-NEOBLADDER FISTULA AFTER RADICAL CYSTECTOMY

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Introduction: Entero-neovesical fistula is a rare complication of orthotopic ileal neobladder after radical cystectomy occurring in less than 2% of cases. The most typical presentation is faecaluria, pneumaturia or recurrent urinary tract infections. Diagnosis is usually confirmed by contrast enhanced abdomino-pelvic computed tomography (CT). Surgical treatment is usually required and includes open resection of the affected bowel tract and reconstitution of bowel transit. Here we present a case of a laparoscopic treatment of entero-to-neobladder fistula 8 years after laparoscopic radical cystectomy.
Objective: To demonstrate the feasibility and safety of minimally-invasive laparoscopic treatment of entero-to-neobladder fistula after laparoscopic radical cystectomy.
Material and Methods: We performed a surgical correction of entero-to-neobladder fistula by laparoscopic approach 8 years after laparoscopic radical cystectomy. The patient was positioned in Trendelenburg position and 5 trocars were introduced in abdominal cavity. The first step, was to separate abdominal adhesions in the peritoneal cavity and

suspend the sigmoid colon. Second, the ileal loop in contact with the neobladder was isolated and the neobladder was separated from iliac vessels and the left ureter was safely exposed. Third, the ileal segment was cut proximally and distally with endoGYA. Fourth, the segment was carefully dissected from the neobladder. Fifth, multiple stones were removed from the opened neobladder. Sixth, the neobladder was closed with a running suture. Lastly, the ileal transit was reconstructed with endoGYA stapler.

Results: We present here a case of a 77-year-old male with a previous muscle-invasive urothelial carcinoma of the bladder treated 8 years before with laparoscopic radical cystectomy with an open Studer neobladder. After surgery, the patient presented with recurrent urinary tract infections and in 2017 the patient developed faecaluria. CT-urogram revealed passage of contrast from the neobladder to a ileal loop and ascending colon making the diagnosis of ileal to neobladder fistula. A first conservative treatment was attempted but the fistula did not close and the patient maintained faecaluira. The CT scan before surgery revealed persistence of the fistula and multiple stones in the urinary bladder. We proposed the patient for minimally invasive laparoscopic repair of the fistula and removal of the stones. Immediate resolution of faecaluria was observed and the post-operative period was uneventful.

Discussion: We demonstrate here the feasibility of the minimally invasive repair of an entero-neobladder fistula after radical cystectomy. With the develpement of minimaly invasive (laparoscopic or robotic) cystectomy the rare cases of entero-neobladder fistula could also be surgical treated with a minimally invasive approach.

VIDEOS IN DISPLAY

V 08

NEFRECTOMIA PARCIAL LAPAROSCÓPICA: TUMOR DA FACE POSTERIOR DO RIM DIREITO COM UTILIZAÇÃO DE TACHOSIL

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Introdução: A nefrectomia parcial é o tratamento recomendado para tumores localizados de pequenas dimensões. Esta técnica permite a preservação de nefrónios. A abordagem laparoscópica é uma via menos invasiva com morbilidade e resultados oncológicos comparáveis à via clássica. Uma das complicações mais frequentes desta abordagem é a hemorragia peri e pós-operatória. Devido ao espaço limitado e à dificuldade técnica de sutura várias formas de renorrafia foram desenvolvidas. Os agentes hemostáticos artificiais (Surgicel, Floseal e Tachosil) foram também um passo importante no controle hemorrágico.
Objectivos: Este vídeo tem como objectivo mostrar os diversos passos da nefrectomia parcial, nomeadamente as dificuldades técnicas de um tumor profundo e na face posterior. Estes factos implicaram a dissecção de todo o rim de forma a ter acesso ao tumor bem como a utilização de várias suturas e agentes hemostáticos de forma a controlar a hemorragia.
Material e métodos: Doente de 63 anos de idade com antecedentes de tabagismo, enfarte agudo do miocárdio e dislipidémia. Incidentaloma do rim direito em TAC pedida pelo médico de família. Foi submetido a nefrectomia parcial direita por laparoscópica 3-D.
Resultados: Neste vídeo consegue-se ver os diferentes passos da nefrectomia parcial: dissecção do hilo renal, dissecção do rim, deslocação do rim para a zona média, isolamento do tumor, clampagem da artéria renal, excisão do tumor, renorrafia com colocação de surgicel na loca, desclampagem da artéria renal, e sutura com utilização de Tachosil.
Conclusões: Nestes tumores profundos e com um acesso mais difícil a utilização de agentes hemostáticos poderão ser uteis no controle da hemorragia. É igualmente importante referir que com tumores profundos com uma loca mais extensa é muitas vezes necessário uma sutura mais extensa sacrificando algum tempo de clampagem.

V 09

MCANINCH PENILE CIRCULAR SKIN FLAP URETHROPLASTY IN A RELAPSING COMPLEX ANTERIOR URETHRAL STRICTURE

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Introduction and objectives: Urethral strictures are a common urological problem, being bulbar urethra most frequently affected. Long strictures are usually not amenable to excision and primary anastomosis, therefore requiring either grafts or flaps procedures. Currently, a preferred approach is yet to be consensually

determined considering that the patency rates and post-operative morbidity are comparable. We present a 1-stage penile circular fasciocutaneous skin flap urethroplasty technique, previously described by McAninch, as a treatment option for a relapsing anterior complex urethral stricture.

Material and methods: We present a case of a 38-year-old male with an idiopathic urethral stricture, previously submitted to an direct vision internal urethrotomy in 2008 and an oral mucosal graft (OMG) dorsal onlay bulbar and dorsal inlay penile urethroplasty in 2011. In 2018 he developed acute urinary retention with subsequent need for suprapubic cystostomy. Retrograde urethrogram showed an 8cm penobulbar urethral stricture. Patient was unable to perform a voiding cystourethrography. Due to length and relapsing nature of the stricture, despite previous attempts with free grafts, a McAninch penile skin flap urethroplasty was proposed between the two.

Results: The patient was positioned in lithotomy and a perineal incision was performed followed by dissection of the bulbar urethra. Extensive fibrotic periurethral tissue was found and removed. Sharp transection of the urethra was performed proximally and distally in a total length of approximately 8cm. The foreskin was used as a circular fascial nonhirsute skin flap. The flap was split dorsally and mobilized on the dartos fascia through perineal dissection. Tubularization was done over a 16Ch foley catheter followed by the proximal and distal anastomosis with 3-0 absorbable monofilament individual sutures. Finally, the flap was secured to adjacent tissues and a Jackson-Pratt drain was placed. Bladder catheter was removed at 4 weeks post-operative and cystostomy catheter at 6 weeks. Urethrogram before catheter removal did not show contrast extravasation. Urofluxometry at 8 weeks revealed a max peak flow rate of 12mL/s for a voiding volume of 150mL and a post-void residual (PVR) volume of 30mL. Currently the patient has resumed sexual activity with good erectile function, nonetheless reporting post-void dribbling and retrograde ejaculation, most likely due to perineal muscle and nerve injury during dissection.

Conclusions: Penile circular skin flap urethroplasty is a safe and effective procedure. The single-stage procedure has a higher patency rate compared to staged techniques and offers a better quality of life, especially in younger patients. Furthermore, it is a particularly useful technique in relapsing complex urethral strictures, namely in patients with poor oral health or who lack mucosa donor sites. There is no consensus regarding the optimal technique, in what concerns the native tissue (graft vs flap), the nature or the shape of the flap tissue, therefore the preferred approach should take in consideration the center's surgical practice and expertise of the surgeon.

V 10

ABORDAGEM ROBÓTICA NO SÍNDROME DE ZINNER

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Caso clínico: Homem de 22 anos

Sem história pregressa de relevo.

Encaminhado em 2021 a consulta de Urologia por quadro de dor perineal com uns meses de evolução, agravada com ejaculação.

Referia ainda polaquiúria e sensação de esvaziamento incompleto.

Ao exame objetivo a referir próstata tensa com desconforto ao toque, sem outras alterações.

Ecografia vesical e próstatica revelou estrutura quística junto ao pavimento da bexiga:

divertículo vs quisto das vesiculas seminais.
RM: "Rim direito não visualizado por provável agenesia. Dilatação quística da vesícula seminal direita. Concomitantemente verifica-se dilatação do ducto deferente direito. Observa-se conteúdo com hipersinal T1 espontâneo ao nível do ducto deferente direito (até a região do epidídimo) e vesícula seminal (inclui quisto) por provável elevado conteúdo proteico. Próstata normodimensionada (14 cc), com heterogeneidade de sinal periférica sobressaindo área de hipossinal T2 difuso a direita com hiper-realce arterial, sem washout aparente, de provável natureza inflamatória."
Posteriormente foi pedido espermograma com evidência de azoospermia.
Verificado ainda varicocelo à direita.
Proposto para excisão da vesicula seminal direita + cura de varicocelo por via robótica.
Síndrome de Zinner.
Condição rara associada a anomalia embriológica que se desenvolve na porção distal do ducto mesonéfrico entre a 4ª e 13ª semana de gestação.
Tríade que inclui agenesia renal unilateral com obstrução do ducto ejaculador e quisto da vesícula seminal ipsilateral.
A clínica é variada e inespecífica, incluindo sintomas do trato urinário inferior, hematúria, hematospermia, dor perineal, infeções recorrentes e dor na ejaculação. Em 45% está ainda associada infertilidade.
É habitualmente descoberta de forma incidental entre a 2ª e 4ª décadas de vida, período de maior atividade sexual e reprodutiva.
Reportados menos de 200 casos na literatura.
Cirurgia.
Lise de aderências do cólon à parede abdominal.
Incisão do fundo de saco de Douglas a nível da vesícula seminal.
Identificação do ducto deferente direito e dissecção.
Laqueação do ducto deferente.
Identificação da vesícula seminal direita e dissecção.
Identificação do ureter remanescente.
Laqueação do ureter remanescente.
Continuação de dissecção da vesícula seminal direita.
Remoção de vesícula seminal direita.
Encerramento de brecha peritoneal.
Correção de varicocelo direito.

V 11

PLACEMENT OF AN INFLATABLE PENILE PROSTHESIS IN A NEOPHALLUM WITH A PREVIOUS FAILED SEMI-RIGID PROTHESIS

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Introduction: Phalloplasty has become a key part of gender-affirming surgery for trangender men. Erectile rigidity is amongst the most commonly reported goals of phalloplasty. This is not often achieved by phalloplasty alone, instead, penile prostheses (PP) are typically placed inside the neophallus. In the present work we report the first inflatable three component implantation in patient who had undergone prior phalloplasty and semi-rigid prothesis placement.
Methods: This patient is a 38 year-old transgender male who had received previous phalloplasty with a two cylinder semi-rigid penile which had subsequent mechanical failure and migration out of the neocorpora cavernosa, causing severe perineal discomfort and incapacitating sexual intercourse. We decided to implant a single cylinder inflatable PP, following these steps:
- The procedure was performed in a supine position;
- An urethral Foley catheter was placed;
- A lateral infra-pubic incision was made near each neocorpora and both semi-rigid cylinders were removed;

- Progressive dilation of the right neocorpora was performed using Hegar dilators;
- A rifampicin soaked polytetrafluoroethylene (PTFE) vascular sheath was placed over the inflatable cylinder to prevent erosion, luxation and to facilitate fixation of the cylinder to the pubic symphysis;
- The cylinder was placed inside the right neocorpora and the proximal end was anchored to the pubic bone using Ethibond® stitches;
- Reservoir was placed in the right retroperitoneal space and the pump was implanted inside the neoscrotum.

Results: There were no significant intercurrences and complications observed during post-operative period. The patient reported improvement in sexual function and overall quality of life. After 12 months of follow-up no significant late complications were identified.
Conclusion: Inflatable penile prosthesis placement is a viable option for obtaining erectile rigidity and to provide a preserved sexual function in transgender male patients with neophallus.

V 12

ADRENALECTOMIA DIREITA POR VIA LAPAROSCÓPICA POR METÁSTASE ÚNICA

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Centro Hospitalar Lisboa Central Centre Hospitalier EPICURA Hornu

Introdução: As supra-renais são um local frequente de metastização de outros tumores. As neoplasias primárias mais frequentes deste tipo de metastização são as neoplasias do pulmão, da mama e gastrointestinais.
Objectivos: Apresentação de vídeo de um caso de adrenalectomia direita.
Material e métodos: Este vídeo foi gravado utilizando uma abordagem laparoscópica com visão 3 D. O vídeo foi editado de forma a apresentar os principais passos da cirurgia.
Resultados: Doente do sexo feminino com 73 anos com diagnóstico de carcinoma da mama direita em 2019, submetida a mastectomia radical, quimioterapia e radioterapia. Encontrava-se assintomática e sem alterações relevantes ao exame objectivo. Em TC de controlo constatou-se massa na supra renal direita com 55x43mm suspeita de metastização. A doente foi submetida a adrenalectomia direita por via laparoscópica, dificultada por se encontrar aderente aos grandes vasos. Não se registaram intercorrências nem complicações no pós operatório.
Discussão/Conclusão: A adrenalectomia é uma das opções de tratamento para as metástases solitárias da supra-renal. A via laparoscópica, quando exequível, é um procedimento seguro e com baixa taxa de complicações.

V 13

FULL URETHRAL PRESERVATION DURING LAPAROSCOPIC RADICAL PROSTATECTOMY (FUP-LRP)

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Introduction: One of the main complications of radical prostatectomy remains urinary incontinence. Urethral length preservation is characterized in the urological literature as a main determinant of early continence.
Objective: To demonstrate the feasibility and safety of full urethral preservation during laparoscopic radical prostatectomy.
Material and methods: We demonstrate here our technique of laparoscopic radical prostatectomy with full urethral preservation. The usual steps of laparoscopic radical prosta-

tectomy were followed, diverging only when usually we divide the urethra. Instead, the urethra was preserved, and completely dissected from the prostate. After completing the dissection, the urethra was sectioned and sent with the prostatectomy specimen to histological analysis, to evaluate the oncologic safety of the procedure, and lastly we performed a vesicourethral anastomosis.

Results: We present the case of a 53-year-old male with EAU low-risk localized prostate cancer (PSA 4.28, cT1, Gleason score 6 (3+3)) which was submitted to a nerve-sparing laparoscopic radical prostatectomy. A novel technique of full urethral preservation was performed, in which the urethra was carefully dissected from the prostate. The patient had no post-operative complications and was discharged after 2 days. The urinary catheter was removed after 10 days. The pathologic report revealed a prostatic adenocarcinoma Gleason 6(3+3), with no urethral invasion by the tumour - pT2cNxMxR0. Post-prostatectomy PSA was <0.01 ng/mL. At last follow-up, the patient had full continence and good erectile function with daily tadalafil (5mg).

Discussion: Full urethral preservation is feasible during laparoscopic radical prostatectomy. However, its execution is technically difficult. Pathology of the urethra showed no tumoral invasion, showing its oncological safety as previous reported in the literature. Prospective studies are needed to evaluate the impact of this technique in continence maintenance.

1 - Paparel, P., Akin, O., Sandhu, J. S., Otero, J. R., Serio, A. M., Scardino, P. T., Hricak, H., & Guillonneau, B. (2009). Recovery of urinary continence after radical prostatectomy: Association with urethral length and urethral fibrosis measured by preoperative and postoperative endorectal magnetic resonance imaging. European Urology, 55(3), 629–639. https://doi.org/10.1016/j.eururo.2008.08.057

V 14

LAPAROSCOPIC MANAGEMENT OF PYELODUODENAL FISTULA IN XANTHOGRANULOMATOUS PYELONEPHRITIS

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Introduction and Objective: Xanthogranulomatous pyelonephritis (XGPN) is a rare and destructive form of chronic pyelonephritis. There is frequent involvement of adjacent organs with abscesses and fistulas. We present a video of a laparoscopic nephrectomy due to xanthogranulomatous pyelonephritis, with the intraoperative diagnosis and repair of a pyeloduodenal fistula.

Material and methods: In this video we present a case of laparoscopic right nephrectomy of a pyelonephritic kidney and the laparoscopic management of a pyeloduodenal fistula.

Results: We report the case of a 51-year-old female with no comorbidities, who presented to the emergency department with flank pain and weight loss in the previous month. The physical examination revealed a right flank palpable mass. The blood work was remarkable for a high white blood cell count and C Reactive Protein, with normal creatinine. The computed tomography scan showed a large right kidney with important dilation and densification of the collecting system, caused by a 13mm stone in the lumbar ureter; the inflammatory process extends into the surrounding tissues, with a hepatic abscess and a psoas abscess; this indicates a chronic pyelonephritis compatible with a xanthogranulomatous process.

She was admitted to the Urology ward and started on a long course of antibiotics. The

initial treatment included ultrasound-guided percutaneous nephrostomy placement by the Urology team and hepatic drain placement by the Radiology team. The patient stayed in the hospital for 3 weeks and was discharged after removal of the drains. The definitive treatment of this condition is surgical with nephrectomy, drainage of concomitant abscesses and removal of the involved tissues. Our video presents this patient's surgery.
Initially, the patient was placed in lateral decubitus. The first trocar was inserted with an open technique. We placed 5 transperitoneal trocars, as we usually do for right sided nephrectomies (one with 12mm, one with 10mm and 3 with 5mm). The dissection was started by retraction of the very adherent liver and right colon. When the duodenum was being mobilized, a small fistula started to be evident, and we continued the dissection trying to adequately isolate the fistula. We used a vascular loop and hem-o-lock to reference the fistula. After its isolation, we continued the dissection on the renal lower pole, finding a duplicated ureter. Dissecting along the ureters we found that the fistula connected the duodenum to the renal pelvis. At this point, the fistulous tract was cut with cold scissors and its duodenal end was sutured with vicryl. The dissection continued and the liver was freed, revealing multiple subhepatic abscesses. There was also a important psoas abscess, which was cleaned. The hilum was sectioned with 6cm Endo GIA® and Hem-o-locks and the nephrectomy was completed. The specimen was removed in a retrieval bag. We secured the duodenal suture with an hemopatch® to protect it from the infected area. A multitubular drain was placed and the incisions were closed.
The patient remained on broad spectrum antibiotic therapy after the surgery. A nasogastric tube was in place for 3 days and the patient remained with no food or fluids by mouth during that time. She started food ingestion on day 5 with great tolerance. The patient was discharged after a week with no complications and was therefore cured.
Discussion: Laparoscopic management of xanthogranulomatous pyelonephritis is challenging due to the loss of anatomical planes and densified tissues. In this case, inflammation extended to the liver with the formation of a hepatic abscess and to the duodenum with the creation of a pyeloduodenal fistula. The management of pyeloduodenal fistulas can also be made by laparoscopy, as demonstrated in our video.

V 15

GASTRO-URO COLLABORATION: ENDOSCOPIC TREATMENT OF A LARGE IMPACTED GALLSTONE IN THE DUODENUM USING LASER LITHOTRIPSY, BOUVERET'S SYNDROME

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Introduction: Bouveret's syndrome is classically defined as a gastric outlet obstruction secondary to impaction of a gallstone in the pylorus or proximal duodenum, secondary to an acquired cholecystoenteric or cholecystogastric fistula. Due to its rarity, the diagnosis of Bouveret's syndrome is often delayed and causes a high morbidity and mortality rate. Currently, a preferred approach is yet to be consensually determined.
Objectives: We describe the successful treatment of this entity using an endoscopic technique with LASER Lithotripsy and highlight the importance of interdisciplinary collaboration for the development and implementation of state of the art care in benefit of all patients, urologic or not.

Material and methods: A 78-year-old male patient presented in the emergency department with worsening diffuse abdominal pain, loss of appetite, vomiting and diarrhea for 3 days.

Blood analysis revealed an increased C-reactive protein of 11,5 md/dL(normal range <0.5 mg/dL) with leukocytosis of 21,00 x10 9/L (normal range 4.0-11.0). Alanine transaminase, aspartate transaminase, bilirubin and renal function were normal.

An abdominal CT scan showed a dilated duodenum with an image of calcic density measuring 34mm of highest diameter.

An endoscopy confirmed a cholecysto-bulbar fistula and occlusion of D2 duodenum by a voluminous stone. He was submitted to another endoscopy to try to fragment the stone with Argon plasma 80W/1L with minimal success.

Results: After multidisciplinary consultation between general surgery, gastroenterology and urology, endoscopic LASER lithotripsy of the impacted stone was planned under general anesthesia. A Dornier Lithotripsy 1000nm LASER fiber (12Hz, 1,5J) was used to fragment the stone into smaller pieces. Sizeable pieces were retrieved to the stomach with large forceps. Minor mucosal damage was seen in the duodenum, without any major complication. The total procedure time was approximately 3 hours.

Postoperatively, the patient has fully recovered.

Conclusions: Endoscopic LASER lithotripsy of an obstructed gallstone in the small intestine was performed in a safe and effective manner and should be considered as an option to treat Bouveret's syndrome in selected cases.

The role and utility of working through a multidisciplinary approach for improving clinical decision making and care for many and diverse pathologies is increasing globally and evidence exists of advantage to patients and healthcare professionals.

We presented a remarkable example of collaborative work between different medical specialties with significant impact on the quality of care of this particular patient.

V 16

GLANS RE-SURFACING FOR THE TREATMENT OF LICHEN SCLEROSUS

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Introduction and objectives: Lichen sclerosus is a chronic inflammatory and scarring dermatosis of unknown etiology that often affects the genitals, leading to phimosis and urethral strictures in males if left untreated. They can present with white penile lesions or plaques, itching, painful erections and voiding, and bleeding or ulceration with sexual intercourse. The treatment can include topical steroids or surgery.

Our aim is to show how one patient with severe disease was managed at our centre.

Materials and methods: A 57 year-old man underwent circumcision and meatoplasty. Anatomopathological report showed Lichen Sclerosus. Due to Lower Urinary Tract Symptoms (LUTS), an urethrography was done, showing a stenosis of the entire penile urethra and navicular fossa. A suprapubic catheter was placed, and the patient underwent a dorsal buccal mucosa graft urethroplasty – Kulkarni's technique. He had a recurrence few months after and a dorsal lingual mucosa graft urethroplasty (ASOPA technique) was performed. Despite the improvement of LUTS, the patient was concerned about pain in the glans with frequent peeling, itching and inflammation that did not resolve with steroids. A glans re-surfacing was proposed.

Results: The patient underwent a glans re-

-surfacing with skin from the thigh. After one year of follow-up since the last surgery, he is satisfied with the results. Although sensitivity has not yet fully recovered, he has no pain in the skin of glans and he can have satisfactory sexual intercourse.

Conclusion: Lichen Sclerosus can be a debilitating disease. The video demonstrates that glans re-surfacing can be an option for patients with severe symptoms with satisfactory results.

V 17

CORPO ESTRANHO PENIANO – QUANDO A SOLUÇÃO VAI ALÉM DO UROLOGISTA

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Introdução/Objetivos: Os corpos estranhos penianos são uma causa rara de ida ao serviço de urgência. Podem causar encarceramento com edema subsequente, eventual lesão uretral e necrose.

Material/Métodos: Reporta-se um caso clínico de corpos estranhos penianos.

Resultados: Um homem de 58 anos dirige-se ao serviço de urgência por apresentar um corpo estranho peniano com 12 horas de evolução, não referindo o mecanismo etiológico. Queixava-se somente de dor na glande. Negava queixas urinárias, uso de fármacos e drogas potenciadoras sexuais e antecedentes médicos relevantes.

Ao exame objetivo apresentava um anel metálico a condicionar constrição da glande com edema extenso e objetos metálicos intra-prepúcio de difícil caracterização. Não apresentava globo vesical.

Após anestesia loco-regional na base do pénis, procedeu-se à aspiração de sangue da glande e corpos cavernosos, demonstrando a vitalidade dos tecidos. Tentou-se o deslizamento do anel com lubrificação adequada e a destruição do anel peniano com recurso a alicates, ambas sem sucesso.

Encontrou-se um plano de clivagem entre o pénis e o anel com auxílio de uma pinça-mosquito e, guiados por esta, introduziu-se um farabeuf que conferiu uma superficie de proteção ao pénis.

Recorreu-se ao auxílio do serralheiro disponível no serviço de aprovisionamento e utilizou-se uma rebarbadora de forma a destruir o anel peniano. O processo decorreu com hidratação abundante da interface rebarbadora/farabeuf/pénis com soro de forma a evitar lesões térmicas.

Após remoção do anel, seguiu-se para a exploração do prepúcio com isolamento digitoguiado dos componentes metálicos, com necessidade de incisões milimétricas com bisturi para a sua remoção e respetiva hemostase com fio de sutura.

Após remoção de todos os componentes, o doente referiu alívio sintomático e urinou de forma espontânea.

Teve alta no próprio dia com analgesia e antibioterapia, tendo ficado inscrito para cirurgia reconstrutiva do pénis motivada pelos danos prepuciais causados pelos objetos metálicos.

Discussão/Conclusões: Os corpos estranhos penianos são uma causa rara de vinda ao serviço de urgência, contudo devemos estar preparados para utilizar todas as formas necessárias que permitam a preservação do órgão.

V 18

GIANT BLADDER CALCULUS AND RECURRENT VESICOCUTANEOUS FISTULA IN A PATIENT WITH BLADDER EXSTROPHY

Thiago Guimarães; João Cunha; Miguel Gil; João Guerra; Mariana Medeiros; Vanessa Andrade; Rui Bernardino; Gil Falcão; Francisco Fernandes; Pedro Baltazar; Hugo Pinheiro; João Pina; Frederico Ferronha; Rui Farinha; Luis Severo; José Paulo Patena Forte; José Pedro Cabrita Carneiro; Fátima Alves; Nelson Menezes; Luis Campos Pinheiro

Centro Hospitalar Universitário de Lisboa Central

Introdution: Patients with congenital pelvic abnormalities of exstrophy submitted to repeated reconstructive surgeries are in risk for lithiasis formation and urinary fistula.

Objective: In this video, we present a case of a 31-year-old male with recurrent vesicocutaneous fistula and partial extrusion of the calculus in the lower abdomen.

Material and methods: Clinical data colected from the hospital diary of the patient and video record of the surgery.

Results: In the past, 16 years ago, the patient was submitted to Mitrofanoff continent catheterizable augmentation entero-cystoplasty with bladder closure.

The first episode of vesicocutaneous fistula and bladder lithiasis partial extrusion was in 2010. Stone removal and new bladder closure with coverage with tunica vaginalis flap of the right testis and partial flaps of rectus abdominis was performed under general anesthesia. Closure of the skin with scrotal rotation skin flap was perfomed at the same time. Good response and no recurrence of fistula and stone were achieved after 1-year of regular follow-up.

During the last four months in December of 2019, this patient presented with partial re--extrusion of a giant stone in lower abdomen, multiples urinary tract infections and Mitrofanoff stomal stenosis becoming impossible self-catheterization.

An incision under local anesthesia of stomal stenosis of Mitroffanof to allow recanalization using a 10fr bladder catheter was perfomed with drenage of residual polymicrobial infected urine. Blood tests showed increasing of inflammatory biomarkers and mild renal disfunction. Early empirical broad-spectrum antimicrobial therapy was initiated.

In the CT-imaging patient present a bulky bilobed bladder calculus measuring 9.6 cm with partial extrusion (500UH) and disruption of the anterior wall of the bladder with densification of subcutaneous and prevesical fat, suggesting an infectious process, associated with marked bilateral hydronephrosis with renal atrophy, suggesting chronic obstruction.

With a GoPRO® 7 Hero intraoperative surgical recording he was operated under general anesthesia and antibiotic prophylaxis. Firstly, the bladder was explored to detach the calculus of the walls of the bladder to allow safe removal of the stone. Cleaning and washing of the bladder were perfomed and a 10fr bladder catheter was replaced into mitroffanof and a stoma bag was adapted to the fistula. Patient discharged at 10th day after the surgery without complications.

Conclusion: No adherence to posterior follow-up recommendations, in the first episode probably related to demographic and psychosocial factors combined with the susceptibility of the patients related to repeated reconstrutive surgeries, were involved in the recurrence and evolution of the vesicocutaneous fistula and growing of this giant stone. In this particular case a penile reconstruction and new bladder closure are now necessary. An option is aponeurotic muscle flap, taken from the thigh, to bridge the diastase of the abdominal rectum and prevent fistulization of the urinary reservoir.

V 19

URETHROPLASTY USING ORAL MUCOSA GRAFT OF EXTENSIVE PENILE URETHRAL STRICTURE – A CHALLENGING PROBLEM IN RECONSTRUCTIVE UROLOGY

Thiago Guimarães; João Cunha; Miguel Gil; João Guerra; Mariana Medeiros; Vanessa Andrade; Rui Bernardino; Gil Falcão; Francisco Fernandes; Pedro Baltazar; Hugo Pinheiro; João Pina; Frederico Ferronha; Rui Farinha; Luis Severo; José Paulo Patena Forte; José Pedro Cabrita Carneiro; Nelson Menezes; Luis Campos Pinheiro

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Introdution: There are a number of controversies in the surgical reconstruction of penile stricture and the management of this condition is a challenging clinical problem in reconstructive urology. In general, there is a significant impact in patients' quality of life in both in urinary, sexual function and in mental health.

Objective: To report the surgical reconstruction of penile stricture in our department.

Materials and methods: Data colected from the hospital diary of patient and video record of surgery.

Results: We report a male of 54 years old, who was submitted, under prophylactic antibiotic therapy (cefoxitin 2g) and general anesthesia to a urethroplasty. A rectangular oral mucosa graft from the left cheek was used considering the appropriate length, diameter, and depth, to repair penile urethral stricture. Pre-operatory urinary flow rate was 5,4ml/s. Retrograde Urethrocystography showed a marked reduction in caliber in the anterior 2/3 of the penile urethra (in an extension of 4.5 cm and about 2 mm in caliber). Duration of surgery: 155 minutes. The patient was discharged 2 days after the procedure. Bladder catheter was removed at the 48th day. The were no intercurrences during the surgery or post-operatory period. Urinary flow rate after 1-year follow-up was 12,5ml/s. Follow-up flexible urethrocystoscopy showed a circular ring in the distal urethra without resistance to device. Improvement in quality of life was achieved and there was no recurrence of stricture after procedure.

Discussion / Conclusion: Different techniques have been suggested for repair of penile urethral stricture. In our practice, urethroplasty using an oral mucosa graft is safe, effective and a useful technique for repairing a long and complicated penile stricture.

V 20

ABLAÇÃO ENDOSCÓPICA DE FOLÍCULOS CAPILARES NA URETRA - UM CASO CLÍNICO

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Introdução: A presença de pêlos na uretra é uma complicação tardia, descrita após uretroplastia ou correção cirúrgica de hipospádias. O tratamento endoscópico com laser é uma opção terapêutica, ainda que raramente descrita na literatura, minimante invasiva, para o tratamento de doentes sintomáticos devido à presença de pêlos na uretra.

O video a seguir apresentado reporta o tratamento cirúrgico, através da ablação endoscópica de folículos capilares na uretra, com recurso a laser Holmium.

Descrição do caso clínico: Doente do género masculino, com 46 anos de iade, observado no serviço de urologia após quadro de dor uretral e retenção urinária aguda, com necessidade de algaliação.

Tinha antecedentes cirúrgicos de correção de um hipospádias congénito com retalho cutâneo na infância.

A cistoscopia realizada na consulta revelou a presença de uma área do lumen uretral obstruido por pêlos. Restante uretroscopia revelou adicionalmente a presença de duas

subestenoses da uretra bulbar, transponiveis com cistoscópio, aparentemente sem importância clínica.
Restante estudo urológico sem alterações.
Na sequência desta observação, foi realizada a ablação endoscópica dos folículos pilosos uretrais com recurso a laser holmium.
O doente ficou algaliado durante uma semana.
Conclusões: Na avaliação pós operatória, às 3 semanas, o doente referia melhoria dos sintomas miccionais, nemeadamente do jato urinário.
À data do presente trabalho não temos, no entanto, dados sobre os resultados deste tratamento a longo prazo.

V 21

LAPAROSCOPIC PUDENDAL NERVE RELEASE – STEP-BY STEP TECHNIQUE

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Introduction and objectives: Pudendal neuralgia caused by pudendal nerve entrapment is a chronic and severely incapacitating neuropathic pain syndrome. It is mostly underdiagnosed and causes significant impairment of quality of life. The pudendal nerve entrapment between the sacrospinous and sacrotuberous ligament is the most frequent aetiology of pudendal neuralgia. With the increasing use of laparoscopy in urology, laparoscopic pudendal nerve decompression is an optional treatment modality besides conservative options like analgesics, physiotherapy, pudendal nerve block, and open surgical nerve decompression. The aim of this study is to demonstrate the safety and feasibility of the laparoscopic approach to perform pudendal nerve release in a case of pudendal nerve entrapment syndrome.
Materials & methods:A video tutorial that highlights the laparoscopic steps to performing pudendal nerve release.
Results: A 54 years-old female patient with incapacitating chronic perineal pain and dyspareunia submitted to Laparoscopic Pudendal Nerve Release. The patient was discharge in the day after the surgery. At the first post-operative consultation, 6 weeks after the surgery, the patient reported significant improvement from previous symptoms.
Conclusions: This video demonstrates the safety, feasibility and reproducibility of laparoscopic pudendal nerve release from the sciatic spine through the Alcock's canal. It represents a validated minimally invasive approach to treat the pudendal nerve entrapment syndrome.

V 22

PARTIAL NEPHRECTOMY: THE RELEVANCE OF SURGICAL SKILLS FOR TECHNICAL FEASIBILITY

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Introduction: Renal cell carcinoma (RCC) accounts for approximately 3% of malignancies in adults. Nephron sparing surgery is nowadays the gold standard treatment for renal masses smaller than 7 cm. However, the feasibility of a partial nephrectomy is limited by patient anatomy, tumor features and surgeon's experience.
Objectives: Our aim is to present a video of a robotic partial nephrectomy for a cystic tumor where surgeon expertise has proven to be crucial to the feasibility of the surgery in an effective and safe way.
Materials and methods: A video recording of a robotic partial nephrectomy performed in March 2021 in our institution.
Results: A 59-year-old male, paraplegic, with a history of spinal cord injury (T10 level), was

incidentally diagnosed with a Bosniak IV cyst with 40 mm on the left kidney. He was refused for partial nephrectomy two other institutions. Pre-operative serum creatinine was 1.0 mg/dL. After discussion the potential benefits and risks of the surgery decision was made to proceed with a robotic partial nephrectomy. Warm ischemia time was 28 minutes and intraoperative bleeding registered was 100 mL. The postoperative course was uneventful. Histology confirmed an RCC, clear cell subtype, grade 4 (WHO/ISUP), with 10% of sarcomatoid pattern and 15% of tumor necrosis, pT1aR0. On first month post-operative creatinine was 1.1 mg/dL. He is on his 4th month of follow-up.

Conclusion: The best treatment approach to renal masses rely on patient and tumor characteristics and surgeon/hospital experience. Tumor anatomic complexity seems to be associated with a higher risk of peri-operative complications and should be taken into account when deciding upon a nephron-sparing surgery. Compared to conventional surgery, minimally invasive approaches, either laparoscopic or robotic, showed similar perioperative complication rates and shorter hospitalization. Additionally, robotic surgery registered less warm ischemia time versus laparoscopic approach. In our patient's case, surgeon expertise allowed to perform a robotic partial nephrectomy despite the high level of complexity, without prejudice of the oncological or functional results and without peri-operative complications registered.

V 23

LAPAROSCOPIC PROMONTOFIXATION REDO - KEEP IT SIMPLE

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The morbidity of mesh-related complications corrections has gained
visibility in the recent years. This will be more evident in our near future.
Often known as a surgeon "nightmare", it is important to remember to go back to basics and give it an opportunity.

V 24

STAGED BUCCAL MUCOSA URETHROPLASTY IN URETHROCAVERNOUS FISTULA WITH PANURETHRAL STRICTURE

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Urethrocavernous fistula is a rare event whose diagnosis requires a high level of suspicion. We present a case that was managed with a staged of buccal mucosa urethroplasty.

V 25

ADRENALECTOMIA POR RETROPERITONEOSCOPIA: UM CASO DE SUCESSO

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Introdução: A adrenalectomia laparoscópica pode ser feita por via transperitoneal ou retroperitoneal. Apesar da via transperitoneal ser mais utilizada, a abordagem retroperitoneal pode ser eleita, para evitar a entrada no peritoneu e, como tal, reduzir o risco de lesão de

órgãos intraperitoneais.
Uma revisão sistemática da Cochrane analisou 5 ensaios clínicos randomizados, com um total de 244 participantes, para comparar as duas abordagens. Apesar da escassez da evidência e de serem necessários mais estudos, o tempo necessário para iniciar dieta oral e deambulação no peri-operatório e a morbilidade a longo prazo, mostraram ser inferiores nos doentes submetidos a cirurgia por via retroperitoneal.
Neste vídeo, é apresentada uma adrenalectomia esquerda laparoscópica por via retroperitoneal realizada no Serviço de Urologia do Centro Hospitalar Tâmega e Sousa.
Descrição do caso clínico: Doente do sexo feminino, de 79 anos, com antecedentes de diabetes mellitus tipo 2 e hipertensão arterial mal controlada, com crises hipertensivas. Associadamente, apresenta queixas de ansiedade, palpitações, cefaleias e hipersudorese.
Foi enviada à consulta externa de Urologia por incidentaloma da suprarrenal esquerda (em Tomografia Computorizada) com 32x24mm com densidade espontânea superior a 10 unidades de Hounsfield, captante de contraste. As catecolaminas plasmáticas e urinárias estavam aumentadas: metanefrina plasmática de 3821 pmol/L e normetanefrina plasmática de 2481 pmol/L; adrenalina urinária de 1397 nmol/dia e noradrenalina urinária de 727 nmol/dia. Foi feito o diagnóstico de feocromocitoma e a doente iniciou bloqueio com fenoxibenzamina.
Foi submetida a adrenalectomia esquerda por retroperitoneoscopia no dia 13 de setembro de 2021.
Foi feita uma incisão subcostal (12ª costela) e dissecou-se a parede abdominal até ao espaço retroperitoneal. Foi criado o espaço de trabalho através da introdução de soro fisiológico em dedo de luva. Foram introduzidas mais 3 portas de trabalho sob visão (uma de 10mm e duas de 5mm). Foi identificado o músculo psoas ilíaco e, posteriormente, a veia suprarrenal. Foi feita a sua clampagem com Hem--o-lock e a disseção da glândula suprarrenal. Após revisão da hemóstase, foi extraída a peça operatória, colocado dreno no espaço retroperitoneal e encerradas as portas de acesso. A cirurgia teve uma duração total de 2 horas, com perdas sanguíneas estimadas de 20 mL.
A cirurgia e o período peri-operatório decorreram sem intercorrências.
O resultado anatomopatológico confirmou o diagnóstico de feocromocitoma, sem invasão da cápsula ou dos tecidos moles periadrenais e com margens cirúrgicas negativas.
Conclusão: A via retroperitoneal na adrenalectomia laparoscópica parece ser uma técnica adequada e segura no tratamento cirúrgico de tumores da suprarrenal.

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LAPAROSCOPIC NEPHROURETERECTOMY OF A NON- FUNCTIONING PELVIC KIDNEY WITH AN ECTOPIC URETER

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Introduction: Nephrectomy for pelvic kidneys represents a surgical challenge, owing to their anomalous anatomy and diverging from everyday, routine cases. We present one such case - a laparoscopic nephroureterectomy of a patient with a pelvic kidney and a ectopic ureter
Objectives: To describe the surgical steps of a laparoscopic nephroureterectomy of a pelvic kidney with an ectopic ureter.
Methods: A 31-year-old male with multiple interventions for congenital abnormalities is submitted to a nephroureterectomy of a non-functional pelvic kidney with an ectopic ureter, for the management of persistent bacteriuria with recurrent urinary tract infections. The

main surgical steps are highlighted in video format.

Results: A surgical video of a nephroureterectomy of a nonfunctional pelvic kidney with an ectopic ureter is presented. Attention is directed towards the importance of pre-operative planning and careful surgical dissection, to avoid iatrogenic injury in the face of non-familiar anatomy.

Conclusions: Laparoscopic nephroureterectomy for pelvic kidneys is a safe procedure, with an easier recovery time for the patient and a short hospital stay. Pre-operative planning, namely for the identification of supra--numerary and anomalous vasculature is key for a good surgical outcome.

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KIDNEY RETAINED FRAGMENTED DOUBLE J STENT - A CHALLENGING PROBLEM FOR UROLOGIST WITH POTENTIAL MEDICO-LEGAL SERIOUS IMPLICATION

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Introduction: Polyurethane double-J ureteral stents are widely used in Urology. Sometimes during a procedure, it is not possible to remove completely double-J ureteral stent and, forgotten ureteral stents, even a piece of them, is not only harmful for the patient but also a potential serious medico-legal problem for the urologist.

Objectives: To report an unusual case of calcified proximal ureteral stent pigtail removal by F-URS with Dormia.

Materials and methods: Surgery was recorded with a digital single-use flexible ureteroscope – EU-Scope™ Model:US31B-12 from Anquing Medical/Endotécnica and a digital Ureteroscope control unit. Real time video of fluoroscopy was recorded with a digital camera. Patient's clinical data was obtained from his clinical registry.

Results: A 66-year-old man underwent surgery to right ureteral double J stent 6ch/26cm (ROCAMED®) in 10/20 insertion, due to acute kidney injury caused by a ureteric stone, in 05/21. Fragmentation of bladder stone surrounding distal pigtail, fragmentation of right pelvic ureteric stone and partial fragmentation of proximal calcified ureteral stent was performed. During the procedure, there was a rupture of the stent at its proximal segment. The distal part of the double-J ureteral stent was removed and a new one was placed. The proximal calcified pigtail of previous stent wasn't removed and patient returned on 09/21 for surgical intervention. First, the previous ureteral stent 6ch/26cm was removed with a foreign body forceps. We perfomed catheterization, ascendant pyelography and placement of 180-cm, 0.035-inch straight--tip hydrophilic coated guidewire, (Glidewire, Terumo, USA) to access right renal collecting system, allowing a safe semirigid ureterorenoscopy. Using a semirigid ureteroscope and PulseLine™ 300 Holmium (Lumenis®) fiber, we fragmentated obstructive ureteric stones to access the right kidney collecting system. With a F-URS we fragmentate the calculi in the right renal region surrounding the proximal part of the double-J ureteric stent. Proximal pigtail was removed with Dormia® No--Tip basket (Coloplast©). New right ureteral double J stent 6ch/26cm was placed. Time of surgery: 57min. The patient was discharged one day after surgery and safe removal of the double J stent 6ch/26cm was performed by cystoscopy 3 weeks after the procedure.

Conclusion: Removal of proximal fragmented

double-J ureteral stent can be frustrating and technically challenging, and may require ureteroscopic, percutaneous or open approach. Accidental rupture ureteral double J stent often occurs after loss of its strength, elasticity and flexibility. Longer indwelling time of the stent is associated with higher risk of crystallization and accidental rupture during its removal.