

patient was mobilized and discharged without any problem on postoperative first day. Histopathological evaluation revealed ganglioneuroblastoma and chemotherapy was planned by oncology department.

CONCLUSIONS: Laparoscopic adrenalectomy in children is a safe and feasible procedure with good results. It can be used successfully in the management of appropriately selected pediatric patients by the teams experienced in laparoscopy.

VS04 Female Urology / Pediatrics

VS04-01 PCNL IN A 18 MONTHS OLD BABY. BIG CHALLENGE EASY SOLUTIONS

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OBJECTIVE: The management of lithiasis in children is currently considered a challenge, not only for the complexity of lithiasis itself but for the special anatomy of the children. The introduction of shock wave lithotripsy (SWL) has changed this perception, but the advent of the endourological techniques has the bigger impact with the equipment designed specifically for these patients. The first series in percutaneous nephrolithotomy were reported by Woodside in 1985. The indication for this procedure includes staghorn stones, stones over 1 cm, failed SWL. Despite we have high complexity urological centers in our milieu, we don't have the suitable instrumental to carry out a percutaneous nephrolithotomy in little children under 2 years.

The objective of our work is to show and report the adaptation and use of the adult endourological instruments to achieve with success a percutaneous nephrolithotomy in 18 months old child. This is a challenge and an innovative technique.

METHODS: We performed a percutaneous nephrolithotomy in a 18 months old female, with a renal stone of 2 cm in size. The adaptation of adult endourological instruments was made with a 14 fr ureteral access sheath that was cut, we use a flexible 6.8 fr tip ureteroscope instead a flexible nephroscope and 9.5 rigid pediatric cystoscope as a rigid nephroscope.

RESULTS: Patient was successfully treated with this innovative technique, minimal morbidity and stone free.

CONCLUSIONS: The adaptation of the adult endourological instruments is safe, reproducible and successful to perform percutaneous nephrolithotomy in children under 2 years.

VS04-02 TRANSURETHRAL COMPLETE REMOVAL OF INTRAVESICAL RIGHT LATERAL ARMS OF A CYSTOCELE MESH

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OBJECTIVE: We present a video of a transurethral complete removal of the right lateral arms of a cystocele mesh, which were passed through the bladder wall. The intravesical portion of the

mesh was cut-off, using laparoscopic scissors, and then extracted.

METHODS: A 54-year-old female was referred to our department because of persistent mild hematuria, after cystocele surgery. Two weeks earlier, she had a cystocele synthetic repair, with a trans-obturator 4 arms polypropylene mesh. Clinical examination noted a marked vaginal tenderness. Diagnostic cystoscopy revealed intravesical mesh perforation, less than 1 cm lateral of the right ureteral orifice. Under spinal anesthesia in the lithotomy position, cystoscopy is performed using an 18 Fr nephroscope, without its 20.8 Fr outer sheath. A 5 mm laparoscopic shears are advanced beside the nephroscope, through urethra. Both arms of the mesh are cut-off at the mesh junction. A strong alligator forceps is advanced through the working port of the nephroscope and both right trans-obturator arms are completely removed. Then, an 18 Fr Foley catheter is inserted.

RESULTS: The transurethral total removal of the right arms of the polypropylene mesh was possible in 40 min. the Foley catheter was removed the 10th postoperative day. No complication was noted, especially, no vaginal fistula or infection. The patient is asymptomatic with no cystocele recurrence after a follow-up of 34 months.

CONCLUSIONS: For a bladder mesh perforation, the transurethral route can be easily performed and might be less invasive, with low morbidity, than open surgery.

VS04-03 ROBOTIC REPAIR OF VESICOVAGINAL FISTULAE - TRANSPERITONEAL TRANSVAGINAL APPROACH

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OBJECTIVE: Prior robotic repair of vesicovaginal fistula has been described using transperitoneal extravesical and transvesical approaches. We describe the transperitoneal transvaginal approach.

METHODS: A 47-year-old woman who underwent abdominal hysterectomy, presented symptoms of urine leakage per vagina post-operatively. The patient failed conservative treatment, laparoscopic vesicovaginal fistula repair and endoscopic fulguration. Cystoscopy revealed a 2 cm opening on the bladder behind the left ureteral orifice. A 10 Fr Foley catheter is placed through fistulous tract from the vagina to the bladder. The surgical steps are: an omental flap is prepared and mobilized robotically, a stay suture is placed in the bladder and exteriorized, the vagina is identified with digital guidance and is incised, the fistula tract is excised, bladder and vaginal walls are dissected and separated,