

cifically, women with a history of post-menopausal bleeding, endometrial hyperplasia and cervical dysplasia may not be appropriate candidates.

METHODS: The featured patient is a 73 year old woman with symptomatic pelvic organ prolapse. Her physical exam revealed anterior predominant stage III pelvic organ prolapse. On exam with valsalva, her anterior vaginal wall extended 3cm beyond the hymen and her cervix was at the level of the hymen. She was not noted to have significant posterior compartment prolapse. She wishes to resume sexual activity after prolapse repair and to preserve her uterus. After counseling, she elected to undergo a transvaginal sacrospinous hysteropexy, anterior repair with mesh, given her high stage cystocele, and a retropubic midurethral sling.

RESULTS: The procedure was completed with minimal blood loss and a total operative time of less than 90 minutes, including the anterior repair and the midurethral sling. The patient was successfully discharged home on postoperative day #1.

CONCLUSIONS: In conclusion, a properly performed sacrospinous hysteropexy provides excellent apical and cervical support and obviates the need for any significant use of mesh. The transvaginal procedure provides a proven method for the management of vaginal vault suspension in women who prefer a uterine sparing technique. The extraperitoneal approach and preservation of the uterus leads to reduced morbidity, and provides an attractive option for both the patient and the surgeon well versed in transvaginal surgery.

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V244

DORSAL VAGINAL GRAFT URETHROPLASTY FOR FEMALE URETHRAL STRICTURE DISEASE

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WITHDRAWN

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ROBOTIC REPAIR OF VESICOVAGINAL FISTULAE - TRANSPERITONEAL TRANSVAGINAL APPROACH

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INTRODUCTION AND OBJECTIVES: Prior robotic repair of vesicovaginal fistula has been described using transperitoneal extravesical and transvesical approaches. We describe the transperitoneal transvaginal approach, a novel technique.

METHODS: A 47-year-old woman who underwent abdominal hysterectomy for benign uterine myomas. She presented symptoms of urine leakage per vagina post-operatively. The patient failed a trial of bladder drainage, as well as 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. An omental flap is prepared and mobilized robotically. A stay suture is placed in the bladder using a straight needle and exteriorized to maintain counter traction. The vagina is identified with digital guidance and is incised. The fistula tract is excised. The bladder and vaginal walls are dissected and separated. Cystorraphy is performed in two layers with in an interrupted fashion using an absorbable suture. Vaginal opening is closed with running stitches. Omentum is interposed and anchored between the bladder and the vagina. Flexible cystoscopy is performed to identify the ureteral orifice and catheter, the ureteral catheter is removed, and an 18 Fr urethral catheter is maintained for 15 days.

RESULTS: Urethral catheter was removed after 15 days post-operative, no hematuria was observed, the patient had minimal irritative voiding symptoms postoperatively.

CONCLUSIONS: Using the laparoscopic robotic-assisted transperitoneal transvaginal approach for vesicovaginal fistula repair is a feasible procedure where the fistula tract is identified by intentionally opening first from the vagina, thereby minimizing the bladder incision and potentially the incidence of recurrence as well as irritative voiding symptoms.

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ROBOTIC REPAIR OF COMPLEX VESICOVAGINAL FISTULAE

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INTRODUCTION AND OBJECTIVES: Vesicovaginal fistulas are among the most distressing complications of gynecologic and obstetric procedures. The risk of developing vesicovaginal fistula is more than 1% after radiotherapy for gynecologic malignancies, 1% risk for ureteral and vesical injuries associated with radical surgery, and the incidence of concomitant rectovaginal fistula is 1 to 5%. A fistula is defined as complex by size greater than 2,5 cm, proximity to the ureteral orifices, post-radiation, multiple, recurrent, and/or combined with rectovaginal fistula. We present our robotic technique used in the management of complex fistulas.

METHODS: Three patients were diagnosed with posthysterectomy vesicovaginal fistulae: one with VVF Orly, one with VVF and associated ureteral injury, and 1 patient was a recurrence after an attempt at Cyanoacrylic glue interposition between vagina and bladder. The steps of the technique of robotic repair are (a) cystoscopy wire passage through the fistula tract and ureteral catheterization, (b) placement of robotic ports, (c) lysis of adhesions, (d) colon dissection in case 1 and ureter dissection in case 2, (e) Bladder opening and fistula identification, (f) dissection of the vaginal and bladder wall, (g) closure of the vagina, (h) omental flap interposition, (i) bladder closure, (j) transient loop ileostomy in case 1 and ureteral reimplantation.

RESULTS: Fistula repair was successful in all cases, with a mean operative time of 140 minutes (180 and 120) and estimated blood loss of 216 mL. The length of hospital stay was of 3 days in all cases. The Foley catheter was removed on the 30th day in case 1, 15th day in case 2, and 25 days in case 3. Recurrence at 1 month in case 1 and no recurrence in case 2 and 3.

CONCLUSIONS: Robotic assisted closure of complex fistulae to the bladder is feasible. Wristed instrumentation facilitates appropriate dissection and complex suturing required for successful fistula closure.

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ROBOTIC SACROCOLPOPEXY: USE OF BARBED SUTURES: INTRODUCTION AND OBJECTIVE

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INTRODUCTION AND OBJECTIVES: Since their advent, delayed-absorbable uni-directional barbed sutures have been applied to an increasing array of surgeries, with proponents claiming