

Table 2. Tumor pathology

TUMOR PATHOLOGY	No. (%)
Malignant	17 (100.0)
Benign	0 (0)
Pathologic tumor size, cm	
Median (IQR)	3.5 (2.5)
Positive surgical margins	1 (5.9)
MALIGNANT CELL TYPE AND STAGE	
RCC, chromophobe	12 (70.6)
RCC, clear cell	4 (23.5)
RCC, papillary	1 (5.9)
RCC pathologic stage	
pT1a	14 (82.4)
pT1b	3 (17.6)

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V1086

ZERO ISCHEMIA LAPAROSCOPIC PARTIAL NEPHRECTOMY. PRELIMINARY EXPERIENCE

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INTRODUCTION AND OBJECTIVES: Laparoscopic partial nephrectomy (LPN) remains a technically challenging procedure that requires advanced laparoscopic skill. Bleeding is one of the most fearful complication of LPN. Warm ischemia time is a mainstay issue that could impact on renal function. Video shows two cases of "zero ischemia" laparoscopic partial nephrectomy.

METHODS: In the first case a transperitoneal approach is performed; medialization of colon and isolation of renal vessels. Renal tumour is identified. A controlled hypotension is realized to reduce bleeding without clamping. The renal lesion is excised using cold endoshears. Parenchyma is repaired with Vicryl™ sutures arrested with Hem-O-lok™ clips. Application of Floseal™ covered by Surgicell™ precedes peritoneum closure. In the second case resection of tumour is realized without previous vessels isolation. Renal parenchyma is repaired with Vicryl™ sutures. We proceed with application of Floseal™ covered by Surgicell™.

RESULTS: 10 patients underwent laparoscopic partial nephrectomy (4 right, 6 left) without clamping for renal tumour (8 patients) and for renal lithiasis (2 patients). Mean age of the patients was 50.9 years (± 18.7). Mean tumour size was 3.7 cm (± 1.5). Operative time was 175 (± 50.4) minutes; blood loss was 435 (± 280) ml. Two patients required blood transfusion. Mean hospitalization was 7.3 (2.8) days. In one patient postoperative urine leakage required placing of ureteral stent. Histological evaluation revealed a Renal Cell Carcinoma in 5 patients, an oncocytoma in 2 patient, an angiomyolipoma in 1 patient. All surgical margin were negative for cancer.

CONCLUSIONS: Zero-ischemia laparoscopic partial nephrectomy without hilar clamping is feasible and safe. Eliminating global renal ischemia now appears achievable. It allows both preservation from ischemic renal damage and an excellent control of bleeding.

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ROBOTIC PARTIAL NEPHRECTOMY IN A PATIENT WITH AN ORTHOTOPIC LIVER TRANSPLANT

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INTRODUCTION AND OBJECTIVES: There is no consensus in the current literature regarding robotic vs. open partial nephrectomy in patients with prior abdominal surgery. In this video, we demonstrate robotic partial nephrectomy in a patient with prior liver transplant with multiple abdominal adhesions.

METHODS: This is a 40 year old male with a history of liver transplant in 2003. MRI with contrast in April 2012 revealed 1.6 × 1.9 × 2.1 cm mass within the upper pole the right kidney, compatible with a renal cell carcinoma. Patient underwent robotic right partial nephrectomy in July 2012.

RESULTS: The procedure was completed without any complication. Estimated blood loss was 150cc. Preoperative creatinine was 1.0 and Postoperative creatinine was stable around 1.2. Renal Scan showed the differential renal function was 42% right and 58% left postoperatively. Preoperatively, the split function was 45% on the right and 55% on the left. Pathology revealed clear cell renal cell carcinoma. Patient was discharged postoperative day 4.

CONCLUSIONS: We demonstrate that robotic partial nephrectomy is possible without any complications in the setting of a prior liver transplant with multiple intrabdominal adhesions and difficult anatomy.

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RIGHT LAPAROSCOPIC RADICAL NEPHRECTOMY: STEP-BY-STEP

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INTRODUCTION AND OBJECTIVES: Two decades after its introduction, laparoscopic radical nephrectomy is now a standard of care for amenable tumors up to stage T3, and for cytoreductive nephrectomy. The current challenge is appropriately educating practicing urologists and urology trainees in the appropriate techniques to minimize complications. As such, one obstacle is that urologists may never actually witness the most feared complications arising from a given step until they are suddenly faced with the prospect of expeditiously handling them.

METHODS: An international collaboration allowed us to collect multiple videos exemplifying not only proper techniques for right sided nephrectomy, but also complications pertinent to each step. The authors compiled their collective experience to offer tips regarding surgical planning, technical maneuvers pertinent to each step, warnings, potential complications, and their management.

RESULTS: This educational video demonstrates the performance of a conventional right laparoscopic radical nephrectomy. Pertinent complications demonstrated include duodenal injury, gonadal vein injury, stapler malfunction with hemorrhage, and bile duct injury.

CONCLUSIONS: The gold standard treatment in certain upper urinary tract neoplasms is radical nephrectomy and the laparoscopic approach has demonstrated advantages compare with open approach. This unique educational video was compiled demonstrating both the proper technical maneuvers, alongside those leading to major complications. We hope this serves as a didactic tool to use in conjunction with simulator based education and hands-on live training.

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