

was a 37 Y/O female, G2L2 with 2 previous C/S. The patient had Amenorrhea after the last C/S (2 years ago) and lactation for 2 years with no symptoms of Estrogen deprivation. Then, she had monthly gross hematuria (4-5 days), urinary frequency and continence. In the physical examination, the patient had normal digital pelvic exam and there was no sign of Estrogen deprivation. The lab test results showed normal levels of FSH, LH, TSH, E2, T4, Cortisol and negative urine cytology.

Materials and Methods: The procedures performed for the patient include HSG, Cystogram and Cystoscopy.

Result: The resulting diagnosis was HSG & Cystogram: Vesicouterine fistula. At first, the uterus and bladder were sharply dissected. Then, the hole between them was specified by a Hegar dilator. The bladder was lifted by Alice and the uterus hole is secured by two oblique sutures. The Hegar dilator is sent into the bladder and the defect is repaired after being observed. After this, the bladder and uterus sutures are made in two different lines. Omentum is placed between the bladder and the uterus in order to expedite the process of healing and prevent infections. At last, the incision was regularly closed.

Conclusion: After the surgery, the patient had normal (4-5 days) cyclic menstrual pattern and no microscopic or gross hematuria was observed.

VID-08

Minimizing Knot Tying with Barbed Sutures in Robotic Sacrocolpopexies

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Introduction and Objective: Since their advent, barbed sutures have been applied to an increasing array of surgeries, with proponents claiming that the barbs provide for a more secure closure while decreasing operative times by obviating the need for knot tying. We evaluate the feasibility, safety, and efficacy of using the unidirectional barbed V-Loc suture in robotic sacrocolpopexies and compare it with the standard PDS suture.

Materials and Methods: After obtaining IRB approval, we retrospectively reviewed patients who underwent robotic sacrocolpopexies using either the standard suture or the V-Loc suture over a 13-month period.

Results: A total of 21 consecutive patients were evaluated over a 13-month period, all of whom underwent a robotic sacrocolpopexy. Fourteen women underwent a robotic sacrocolpopexy using the V-Loc suture, while 7 underwent surgery using the standard

PDS suture. In the V-Loc group 78.6% underwent a concomitant transobturator tape sling, vs. 85.7% in the standard group. There was 42.9% of the V-Loc group who had a concomitant surgery, compared to 71.4% in the standard group. Average age (V-Loc group: 66.3 years, standard group: 62.6 years) and BMI (V-Loc group: 26.4, standard group: 26.5) were similar between groups. The V-Loc group had a higher percentage of patients with a history of previous prolapse repair (57.1% vs. 14.3% in the standard group) and a lower average POP-Q score (2.2 vs. 2.7 in the standard group). The OR time in the V-Loc group was similar to that of the standard group (267.4 vs. 248.1 minutes), as was EBL (80.0ml vs. 82.9ml). Follow-up time was less for the V-Loc group (6.9 vs 13.6 weeks), and hospital stay and complication rates were similar.

Conclusions: The barbed V-Loc suture can easily be implemented during robotic sacrocolpopexies in a safe and efficacious manner.

VID-09

Robotic Repair of Vesicovaginal Fistulae: Transperitoneal Transvaginal Approach

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

Materials and Methods: A 47-year-old woman 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. Cystorrhaphy is performed in two layers 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.

VID-10

MRI-Navigated Stereotactic Prostate Biopsy

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Introduction and Objective: A key challenge for prostate cancer therapy is to precisely diagnose tumor lesions. Exact information on tumor grade, stage and site is mandatory to counsel men with prostate cancer. For this purpose we developed a novel prostate biopsy system that combines pre-interventional magnetic resonance imaging with peri-interventional ultrasound for perineal navigated prostate biopsy. This platform integrates imaging, TRUS/MRI-fusion, biopsy planning, perineal targeting and 3D-mapping into a single system.

Materials and Methods: There were 106 men with suspicion of prostate cancer (median age 66yrs, PSA 8.0ng/ml, prostate-volume 47ml) who underwent multiparametric 3T-MRI. Suspicious lesions were marked and the data were transferred to the biopsy system. Using a custom-made biplane TRUS-probe mounted on a stepper, 3D-ultrasound data were gathered and fused with the MRI. As a result, suspicious MRI-lesions were superimposed over the TRUS-data. Next, 3D-biopsy planning was performed including systematic biopsies (median 24 biopsies). Perineal biopsies were taken under live US-imaging and the precise location of each biopsy was documented in 3D. Feasibility, safety, and cancer detection were evaluated.

Results: Prostate cancer was detected