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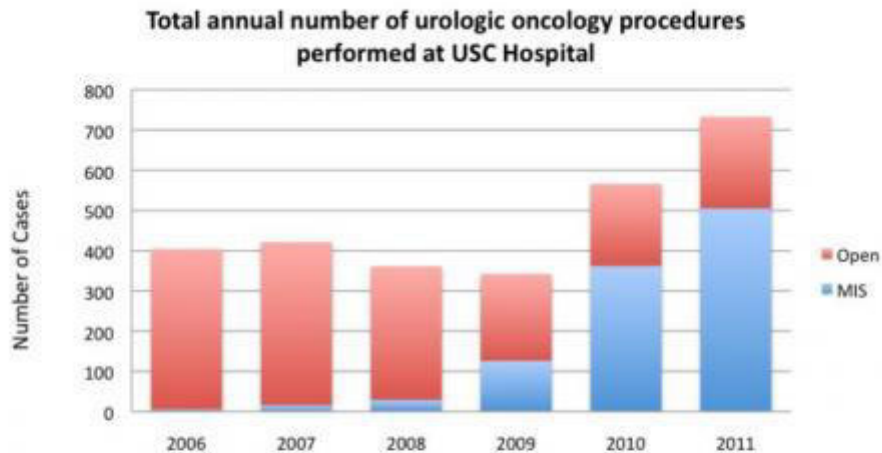
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Purpose: We examined trends in open and minimally-invasive surgery (MIS) for urologic oncology at an established National Cancer Institute (NCI)-designated comprehensive cancer center.

Materials and methods: Prospectively-collected data on all patients undergoing radical prostatectomy (RP), radical cystectomy (RC), radical nephrectomy (RN) and partial nephrectomy (PN) for cancer at University of Southern California (USC) from 2006-2011 were analyzed retrospectively. National trends at teaching hospitals were evaluated from the latest-available Nationwide Inpatient Sample (NIS) dataset (2005-2009).

Results: At USC, the ratio of open:MIS surgeons changed in 2009 from 4:1 to 4:4. From 2006-2011, annual total number of urologic oncology procedures increased 81%; the change was -11% prior to (2006-2008) and +114% after (2009-2011) introduction of MIS. Among all oncologic cases, MIS comprised 2% in 2006 and 74% in 2011 ($P<0.01$). Use of PN compared to RN increased from 24% to 84% ($P<0.01$). While TNM staging and straight-line travel distance remained unchanged, positive RP margin rates ($P=0.006$) and hospital stay for all procedures ($P<0.01$) decreased. Annual proportion of MIS procedures increased significantly for RP (+85%), RC (+10%), RN (+57%) and PN (+87%) (all $P<0.01$). In the NIS cohort, annual proportion of MIS procedures significantly increased for RP (+63%), RC (+18%), RN (+10%) and PN (+26%) (all $P<0.01$).

Conclusions: Use of robotic/laparoscopic surgery for prostate, bladder, and kidney cancer increased at our NCI-designated comprehensive cancer center. This was consistent with national trends in teaching hospitals. These data provide information regarding contemporary tertiary practice patterns and enhance understanding of evolving trends in urologic oncologic surgery in the United States.



Open – no. (% of total)	398 (99%)	405 (96%)	332 (92%)	216 (63%)	204 (36%)	228 (31%)
MIS – no. (% of total)	6 (1%)	16 (4%)	29 (8%)	126 (37%)	362 (64%)	505 (69%)
Total (% change from previous year)	404 (NA)	421 (+4%)	361 (-14%)	342 (-5%)	566 (+66%)	733 (+30%)

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, cystorraphy is performed in two layers with in an interrupted fashion using an absorbable suture, vagina is closed with running stitches, omentum is interposed and anchored between the bladder and the vagina. Flexible cystoscopy identifies 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.

ROBOTIC NEPHROURETERECTOMY TRIFECTA: NO PELVIC DRAIN WITH NEXT-DAY CATHETER REMOVAL AND DISCHARGE

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Introduction: Nephroureterectomy can be performed laparoscopically, but management of the distal ureter is challenging with strategies described to compensate for difficulty replicating open bladder cuff excision and closure. Robotically, improved instrumentation and visualization facilitate bladder cuff excision with closure in water-tight fashion to allow earlier catheter removal and no need for a drain. We attempt to maximize the