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Laparoscopic and Robot-Assisted Surgery in Urology

Atlas of Standard Procedures

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Introduction

Vesicovaginal fistulae (VVF) may be treated by different surgical techniques, either transvaginal or transabdominal (extra- or transvesical). The selection of the approach is based on the surgeon's preference. However, there is still controversy over the ideal approach and time of repair [1, 2]. In general, a vaginal approach is associated with lower morbidity, diminished blood loss and post-operative bladder irritability in comparison to the transabdominal approach. Furthermore, this technique may be performed in the outpatient setting. The results are often equal to those achieved with an abdominal approach [3]. The abdominal approach is indicated in case of another intra-abdominal condition requiring simultaneous surgical management. The abdominal method is also used when the fistula is lying high and/or on the vaginal vaults. Laparoscopy can be an alternative to the abdominal approach for managing VVF. Nezhat et al. initially reported laparoscopic VVF repair in 1994 [4]. Sotelo et al. reported the largest laparoscopic series. The latter group used a transvesical approach that led expeditiously to the fistulous tract without the need for additional vaginal incisions or further dissection of the vesicovaginal space [5]. Moreover, the laparoscopic approach enables a limited cystotomy, which is associated with less morbidity in comparison to the historical O'Connor procedure. During the latter procedure, the bladder is bivalved to the level of the fistula. In general, the advantages of laparoscopy include magnification of the operative field, efficient haemostasis, decreased hospital stay and shorter convalescence.

Indications

- Inadequate exposure related to a high or retracted fistula in a narrow vagina
- Close proximity of the fistulous tract to the ureter
- Associated pelvic pathology that requires surgery
- Multiple fistulae
- Morbid obesity
- Failure in a previous open surgical approach

Contra-indications

- Generalised peritonitis
- Uncorrected or uncorrectable coagulopathy
- Severe co-morbidities contra-indicating any surgical management

Preoperative Preparation

- It is necessary to clearly explain to the patient the type of procedure that will be performed. It is important to address the novelty of the technique and its recent development as a therapeutic option. Risks and complications should be discussed, as well as the possibility of open surgery, owing to anatomical variations or unforeseen complications that might require the open approach
- Most patients are surgically managed after 2 months of unsuccessful conservative management. In case of conservative management failure, a urethral catheter is avoided (if possible) until the day of surgery

Specific Patient Preparation

- Soft diet, at home
- The evening before the procedure, antegrade bowel preparation
- Fasting from 10:00 p.m. on the day before surgery
- Patient is admitted on the day of the procedure
- Preoperative administration of an intravenous broad-spectrum antibiotic (quinolone or cephalosporin)