

VE11 Robotic ureteral reimplantation due to deep infiltrating endometriosis - psoas hitch approach

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Introduction & Objectives: Endometriosis is manifested by the presence of endometrial-like tissue outside the uterus, producing a chronic, inflammatory process. The prevalence of Urinary Tract Endometriosis is about 6-10%. As the standard treatment of deep infiltrating endometriosis is a complete surgical excision of endometriotic implants, urinary tract endometriosis might require reconstructive surgery by an experienced Urologist. The aim of this video is to present a video of Robotic Ureteral Reimplantation with the Psoas Hitch approach, highlighting all key surgical steps in a patient with left ureteral stenosis due to deep infiltrating endometriosis.

Materials & Methods: We present a case of a 37 year-old female patient with no past medical history with complaint of dysmenorrhea and infertility. The patient also reported dyspareunia and vaginal bleeding during intercourse. She was diagnosed with deep infiltrating endometriosis in a Magnetic Resonance Imaging that showed moderate to severe left hydronephrosis initiated at 4cm of the ureteral meatus associated with an 8mm stenosis of left distal ureter. Additionally, the patient presented pelvic endometriosis in retrocervical uterine region measuring 5cm in diameter. There was also Signs of invasion of the posterior vaginal fornix and uterine cervix. Left Ovary presented an endometrioma of 4.7cm. A Multidisciplinary Robotic approach was proposed, and the patient underwent on May, 2020.

Results: Patient underwent Round Ligament excision, Oophoroplasty, Excision of retrocervical endometrioma, partial colectomy and Ureteral Reimplantation with Psoas Hitch procedure on May 22nd, 2020. The bladder mobilization and careful stitching to the psoas muscle (Psoas Hitch) was performed in order to accomplish adequate uretero-vesical anastomosis without tension. Total procedure time was 200 minutes, being 150 for the ablative procedure performed by Gynecologists and 50 minutes for the reconstructive procedure, performed by the Urology team. The total blood loss was 250ml. The post-operative days went uneventfully, and the patient was discharged at 5 POD. The ureteral stent was removed endoscopically at 30 POD and no complications were recorded until 60 POD.

Conclusions: Robotic ureteral reimplant is feasible and safe. Several key aspects of the technique might be carefully observed in order to accomplish good perioperative outcomes. The length of the resected ureter plays a pivotal role when choosing the appropriate technique for reconstruction.