



Vincenzo Disanto

Dear Colleagues, It is a great pleasure to invite you to Leipzig for the 8th European Meeting of "Challenges in Laparoscopy and Robotics".

The scientific program will include live laparoscopic and robotic surgery performed by the world's most renowned surgeons. Interesting presentations and pertinent debates to laparoscopy and robotics will enrich the program and guarantee a scientific program at the highest level.



Elala

Leipzig is an historical city with a rich cultural and commercial profile. Major classical music composers have lived and flourished here. In addition, major car industries (Porsche and BMW) are producing several of their lines in Leipzig.

Clearly, music, action and speed are the major characteristics of this city. This is the perfect city to host "Challenges in Laparoscopy and Robotics". We hope that you will follow the sound, action and speed of this special

program and that this will be a memorable meeting for all of you from a scientific as well as a social standpoint.

Welcome to Leipzig!



Vito Pansadoro

Vincenzo Disanto

Evangelos Liatsikos

Vito Pansadoro

Jens-Uwe Stolzenburg



Jens-Uwe Stolzenburg

Course Directors, Scientific Committee and Local Organizing Committee,
Invited Surgeons, Invited Speakers & Moderators



Course Directors

Course Directors



Vincenzo Disanto, MD
Policlinico Abano Terme
Abano, Italy



Evangelos Liatsikos, MD
University of Patras
Patras, Greece



Vito Pansadoro, MD
Vincenzo Pansadoro Foundation
Rome, Italy



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University of Leipzig
Leipzig, Germany

Scientific Committee and Local Organizing Committee

Scientific Committee

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Abano, Italy

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Clinique Saint Augustin
Bordeaux, France

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University of Southern California
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St. Elisabeth Hospital
Leipzig, Germany

Jens Uwe Stolzenburg, MD

University of Leipzig
Leipzig, Germany

Holger Till, MD

University of Leipzig
Leipzig, Germany

Invited Surgeons



Renaud Bollens, MD
Professor and Chairman
G.H.I.C.L. (Groupe Hospitalier de l'institut
Catholique de Lille)
Lille, France



Inderbir S. Gill, MD, MCH
Chairman and Donald G. Skinner Professor
Department of Urology
Executive Director,
USC Institute of Urology
Associate Dean (Clinical Innovation)
Keck School of Medicine,
University of Southern California
Los Angeles, USA



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Director Transplant Unit
Fondation Puigvert
Barcelona, Spain



Günter Janetschek, MD
Professor and Chairman
Department of Urology
Medical University Salzburg
Salzburg, Austria



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Director, Laparoscopy Center
Policlinico Abano Terme
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Jihad H. Kaouk, MD
Zegarac-Pollock Professor of Surgery
Institute Vice Chair for Surgical Innovations
Director, Center for Laparoscopic
and Robotic Surgery
Glickman Urological and Kidney Institute
Cleveland Clinic
Cleveland, USA



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Department of Urology
Clinique Saint Augustin
Bordeaux, France



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Assistant Professor
Department of Urology
University of Patras
Patras, Greece

Invited Surgeons



Alex Mottrie, MD
Department of Urology
O.L.V.-Clinic
Aalst, Belgium



Jörg Rassler, MD
Chairman Department of Gynecology
St. Elisabeth Hospital
Leipzig, Germany



Vito Pansadoro, MD
Director, Laparoscopy Center
Vincenzo Pansadoro Foundation
Rome, Italy



Jens Rassweiler, MD
Head of Department of Urology
SLK Kliniken Heilbronn
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Vipul Patel, MD
Medical Director of Urologic Oncology,
Florida Hospital
Medical Director of Global Robotics Institute
Associate Prof of Urology
University of Central Florida
Florida, USA



Peter Rimington, MD
Director of Urology
Eastbourne District General Hospital
Eastbourne, UK



Thierry Pièchaud, MD
Center of Urologic Laparoscopy
Clinique Saint Augustin
Bordeaux, France
Chairman of Urologic Courses
IRCAD-EITS, Strasbourg, France



Jens Uwe Stolzenburg, MD, FRCS (Ed)
Professor and Chairman
Department of Urology
Head of International Training Center
of Urologic Laparoscopy
University of Leipzig
Leipzig, Germany

Invited Surgeons



Holger Till, MD

Director, Department of
Pediatric Surgery
University of Leipzig
Leipzig, Germany



Xu Zhang, MD, PhD

Professor and Chairman
Department of Urology
Chinese PLA General Hospital
Beijing, China



Ingolf Türk, MD, PhD

Chief of Urology
Director Robotic
Assisted Surgery Program
St. Elizabeth's Medical Center
Professor for Urology
Tufts School of Medicine
Boston, USA



Roland Van Velthoven, MD

Chairman Department of Urology
Service InterHospitalier d'Urologie
Institut Jules Bordet
Hospital Saint Pierre
Brussels, Belgium



Peter Wiklund, MD

Professor and Chairman
Dept. of Molecular Medicine and Surgery,
Section of Urology, Karolinska Institutet
Stockholm, Sweden

Invited Speakers & Moderators



Chris Anderson, MD
Consultant Urological Surgeon
and Lead Cancer Clinician
Department of Urology
St George's University Hospital
London, UK



Guglielmo Breda, MD
Professor and Chairman
Department of Urology
San Bassiano Hospital
Bassano del Grappa, Italy



Walter Artibani, MD
Professor and Chairman
Department of Urology
University of Padua, Italy



Francesco Curto, MD
Department of Urology, A.R.N.A.S.
Civic Hospital Palermo
Palermo, Italy



Alexander Bachmann, MD
Chairman Department of Urology
University Hospital Basel
Basel, Switzerland



Gianluca D'Elia, MD
Professor and Chairman
Department of Urology
San Giovanni Hospital
Rome, Italy



Harrie Beerlage, MD
Department of Urology
Jeroen Bosch Hospital
Hertogenbosch, The Netherlands



Michael Dunzinger, MD
Head of the Department of
Urology and Andrology
Hospital Voecklabruck
Head of the Board of Laparoscopy
of the Austrian Urological Society
Voecklabruck, Austria

Invited Speakers & Moderators



Paolo Emiliozzi, MD

Department of Urology
San Giovanni Hospital
Rome, Italy



Amir Hamza, MD

Chairman Department of Urology
St. Georg Hospital Leipzig
Leipzig, Germany



Tibet Erdogru, MD

Head Department of Urology
Minimally Invasive & Robotic Surgery Center
Memorial Atasehir Hospital
Istanbul, Turkey



Panagiotis Kallidonis, MD

Department of Urology
University of Rio- Patras
Patras, Greece



Franco Gaboardi, MD

Professor and Chairman
Department of Urology
Sacco Hospital
Milan, Italy



Konstantinos Konstantinidis, MD

Professor and Chairman
Department of Urology
University of Athens Medical School
Laikon General Hospital
Athens, Greece



Giorgio Guazzoni, MD

Professor and Chairman
Department of Urology
Università Vita e Salute
"Ville Turro" San Raffaele Hospital
Milan, Italy



Alan McNeill, MD

Consultant Urological Surgeon and
Honorary Senior Lecturer
Department of Urology
Lothian University Hospitals
Edinburgh, Scotland

Invited Speakers & Moderators



Bülent Oktay, MD
Head Department of Urology
Uludag University Faculty of Medicine
Bursa, Turkey



Bernardo Rocco, MD
Vice Director of Urologic Division
European Institute of Oncology
Milan, Italy



Alberto Pansadoro, MD
Department of Urology
Civic Hospital Terni
Terni, Italy



Constantinos Stravodimos, MD
Assistant Professor of Urology
Department of Urology
University of Athens Medical School
Laikon General Hospital
Athens, Greece



Francesco Porpiglia, MD
Associate Professor
Department of Urology
A.S.O. San Luigi
Orbassano-Torino, Italy



Tullio Sulser, MD
Professor and Chairman
Clinic of Urology
University Hospital Zurich
Zurich, Switzerland



Abhay Rane, MD
East Surrey Hospital
Canada Avenue
Redhill, UK



Peter Tenke, MD
Jahn Ferenc South- Pest
Teaching Hospital
Budapest, Hungary

Invited Speakers & Moderators



Joachim Thüroff, MD

Professor and Chairman
Department of Urology
University of Mainz
Mainz, Germany



Michael Truß, MD

Professor and Chairman
Department of Urology
Klinikum Dortmund
Dortmund, Germany



Manfred Wirth, MD

Professor and Chairman
Department of Urology
Universitätsklinikum "Carl Gustav Carus"
der Technischen Universität Dresden
Dresden, Germany

Congress Program



Wednesday June 8th,
Thursday June 9th,
Friday June 10th,
Saturday June 11th, 2011

1:00—6:00 pm

Coordinators of the Meeting

LAPAROSCOPY BEGINNERS COURSE

Presentations and dry lab training
Storz Training Center

**Evangelos Liatsikos, Francesco Curto,
Alberto Pansadoro**

- Specialized surgical instruments, devices and equipment
- Set up of operating room and patient position
- Indications and contraindications to laparoscopy
- Transperitoneal and extraperitoneal access
- Advantages and disadvantages of different access
- Trocars' position (several surgical procedures)
- Knot tying, Suturing and Haemostasis
- Anatomical landmarks for upper urinary tract
- Anatomical landmarks for lower urinary tract
- Surgical technique for:
adrenalectomy/radical nephrectomy
nephroureterectomy pieloplasty/nephropexy
- Surgical technique for colpopexy/psoas hitch/ureteral, reimplantation/varicocelelectomy
- Management of complications

Hands on Training

- Pelvic Trainer
- P.O.P. (Pulsating Organ Perfusion) Training
- Live Training

8:00 am

Jens Uwe Stolzenburg

Joachim Thüroff

Walter Artibani

Jens Rassweiler

Evangelos Liatsikos

Vincenzo Disanto

Vito Pansadoro

Welcome

Course director

President SIU - Société Internationale d'Urologie

Vice Secretary of the EAU

Chairman ESUT

Course director

Course director

President SIU - Società Italiana di Urologia

8:15—8:30 am

Joachim Thüroff

SIU Lecture

European Experience on open and minimally invasive partial nephrectomy

8:30 am—4:00 pm

Surgical Session

Moderators

Alberto Breda

Evangelos Liatsikos

Renaud Bollens

Jihad Kaouk

Vincenzo Disanto

Inderbir Gill

Jens Rassweiler

Vito Pansadoro

Alex Mottrie

UPPER TRACT

**Guglielmo Breda, Peter Tenke,
Michael Truß, Amir Hamza, Bülent Oktay**

Robotic Donor Nephrectomy

Provoker — **Guglielmo Breda**

Hybrid Nephrectomy

Provoker — **Francesco Porpiglia**

Laparoscopic Radical Advanced Nephrectomy

Provoker — **Alan McNeill**

Single Port Robotic Nephrectomy

Provoker — **Franco Gaboardi**

Retroperitoneal Partial Nephrectomy

Provoker — **Roland Van Velthoven**

Clampless Partial Robotic Nephrectomy

Provoker — **Chris Anderson**

SMART Pyeloplasty with ETHOS-chair

Provoker — **Giorgio Guazzoni**

Ureteral Stricture repair

Provoker — **Joachim Thüroff**

Robotic Partial Nephrectomy

Provoker — **Tullio Sulser**

Thursday, June 9th 2011

Thursday

4:00—4:40 pm

Moderators

Inderbir Gill
Chris Anderson
Evangelos Liatsikos

Debates

Vito Pansadoro, Constantinos Stravodimos

Nephrectomy and Partial Nephrectomy
Standard Laparoscopy vs. Robot Assisted
Laparoscopy vs. LESS
Speaker Lap
Speaker Robot
Speaker LESS/ Needlescopic

4:40—5:20 pm

Moderators

Holger Till
Harrie Beerlage
Jens Rassweiler

Abhay Rane, Francesco Porpiglia

Pyeloplasty
Standard Laparoscopy vs. Robot Assisted
Laparoscopy vs. LESS
Speaker Lap
Speaker Robot
Speaker LESS/ Needlescopic

5:20—6:00 pm

Moderators

Alan McNeill
Giorgio Guazzoni
Jihad Kaouk

Alex Bachmann, Francesco Curto

Nightmares of laparoscopic/robot assisted
upper tract surgery – What you should never
do. Standard Laparoscopy vs. Robot Assisted
Laparoscopy vs. LESS
Speaker Lap
Speaker Robot
Speaker LESS/ Needlescopic

6:00 pm

Adjournment

8:15—8:30 am

Roland van Velthoven

ESUT Lecture

European Experience on Laparoscopic
Radical Cystectomy

8:30 am—4:00 pm

Surgical Session

Moderators

Richard Gaston

Inderbir Gill

Peter Wiklund

Peter Rimington

Roland van Velthoven

Richard Gaston

Holger Till

Jörg Rassler

Jens-Uwe Stolzenburg

PELVIS

**Alberto Pansadoro, Alan McNeill,
Michael Dunzinger, Tullio Sulser**

Robotic Cystectomy

Provoker — **Inderbir Gill**

Robotic extended Lymphadenectomy

Provoker — **Bernardo Rocco**

Robotic Neobladder

Provoker — **Alex Mottrie**

Laparoscopic Cystectomy

Provoker — **Walter Artibani**

Extended Laparoscopic Lymphadenectomy

Provoker — **Paolo Emiliozzi**

Laparoscopic Intracorporeal Bricker

Provoker — **Gianluca D'Elia**

Pediatric Pyeloplasty

Provoker — **Francesco Porpiglia**

Laparoscopic Burch

Provoker — **Joachim Thüroff**

Inguinal hernia repair

Provoker — **Alberto Pansadoro**

Friday, June 10th 2011

Friday

4:00—4:40 pm

Moderators

Peter Rimington
Peter Wiklund
Joachim Thüroff

Debates

Walter Artibani,
Konstantinos Konstantinidis

Cystectomy
Standard Laparoscopy vs. Robot Assisted
Laparoscopy vs. Open
Speaker Lap
Speaker Robot
Speaker Open

4:40—5:20 pm

Moderators

Roland Van Velthoven
Vipul Patel
Manfred Wirth

Joachim Thüroff, Tullio Sulser

Modifications of Radical Prostatectomy
Evidence based data or surgeon's wisdom
Speaker Lap
Speaker Robot
Speaker Open

5:20—6:00 pm

Moderators

Thierry Pièchaud
Jens Rassweiler
Michael Truß

Ingolf Türk, Panagiotis Kallidonis

General management of complications
during Radical Prostatectomy
Vascular injuries
Rectal injury
Anastomotic leakage

6:00 pm

Adjournment

8:15—8:30 am

EAU Lecture

Walter Artibani

Robotics: Just the start of a new era in surgery

8:30 am—3:00 pm

Surgical Session

Moderators

PROSTATE DAY

Vipul Patel

**Harrie Beerlage, Tibet Erdogan,
Amir Hamza, Abhay Rane,
Thierry Pièchaud, Manfred Wirth**

Robotic Assisted Laparoscopic Prostatectomy
Provoker — **Ingolf Türk**

Jens Uwe Stolzenburg

Endoscopic Extraperitoneal Radical
Prostatectomy (with hernia repair)
Provoker — **Michael Truß**

Ingolf Türk

Extraperitoneal Robotic Radical Prostatectomy
Provoker — **Franco Gaboardi**

Richard Gaston

Laparoscopic Radical Prostatectomy
(median lobe)
Provoker — **Chris Anderson**

Jihad Kaouk

Single Port Robotic Radical Prostatectomy
Provoker — **Evangelos Liatsikos**

Günter Janetschek

Laparoscopic Radical Prostatectomy
(with Fluorescence Staining)
Provoker — **Michael Dunzinger**

Xu Zhang

Laparoscopic Radical Prostatectomy
(after TURP)
Provoker — **Tullio Sulser**

3:00 pm

Adjournment

Abstracts

Abstracts



Thursday, June 9th 2011

4:00—4:40 pm

Moderators

Inderbir Gill
Chris Anderson
Evangelos Liatsikos

Debates

Vito Pansadoro, Constantinos Stravodimos

Nephrectomy and Partial Nephrectomy
Standard Laparoscopy vs. Robot Assisted
Laparoscopy vs. LESS

Speaker Lap
Speaker Robot
Speaker LESS/ Needlescopic

4:40—5:20 pm

Moderators

Holger Till
Harrie Beerlage
Jens Rassweiler

Abhay Rane, Francesco Porpiglia

Pyeloplasty
Standard Laparoscopy vs. Robot Assisted
Laparoscopy vs. LESS

Speaker Lap
Speaker Robot
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5:20—6:00 pm

Moderators

Alan McNeill
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Jihad Kaouk

Alex Bachmann, Francesco Curto

Nightmares of laparoscopic/robot assisted
upper tract surgery – What you should never
do. Standard Laparoscopy vs. Robot Assisted
Laparoscopy vs. LESS

Speaker Lap
Speaker Robot
Speaker LESS/ Needlescopic

6:00 pm

Adjournment

Thursday, June 9th 2011

Thursday

Laparoscopic Nephrectomy and Partial Nephrectomy

Inderbir S. Gill

Chairman and Donald G. Skinner Professor

Department of Urology

Executive Director,

USC Institute of Urology

Associate Dean (Clinical Innovation)

Keck School of Medicine,

University of Southern California

Los Angeles, USA

Robotic Nephrectomy and Partial Nephrectomy: is robotic technology facilitating minimally invasive renal surgery

Chris Anderson

Consultant Urological Surgeon
and Lead Cancer Clinician
Department of Urology
St George's University Hospital
London, UK

Up to 50% of all renal tumors diagnosed today are <4cm in diameter, and they are usually detected in asymptomatic and frequently old and infirm patients. About 20% of these small renal tumors (SRT) are actually benign and the majority have a low potential to progress. As a result less invasive energy ablative and even active surveillance strategies are becoming increasingly more popular. ~ 10% of SRTs have morphologic parameters suggesting higher aggressiveness, and this increases to ~30% in tumors 3-4cm in diameter. Imaging can not identify these more dangerous SRTs. If a therapeutic decision other than standard surgical removal is taken it should therefore be based on a biopsy. In our experience a CT guided core needle biopsy performed in local anesthesia as a separate procedure (no frozen sections) provides adequate specimens in 97.5% of patients. It has a 95.2% sensitivity, 100% specificity, 100% positive predictive value and 81.3% negative predictive value for the diagnosis of malignant vs. benign tissue. Histologic subtype and Fuhrman grade can be correctly identified in 91% and 76% respectively. In contrast fine needle aspiration biopsies under similar conditions provided insufficient material in 11% of biopsies, and sensitivity and negative predictive value were only 90.6% and 70%, respectively. In 118 biopsies complications were observed in 4% of patients. They were always minor and most commonly formation of hematomas, and never needed further intervention.

Remzi, M, Marberger, M: Eur.Urol.2009:55,359-367

Schmidbauer et al.: Eur.Urol.2008:53,1003-12

Remzi et al: J.Urol. 2006:176,896-9

LESS/ Needlescopic Nephrectomy and Partial Nephrectomy

Evangelos Liatsikos

Assistant Professor
Department of Urology
University of Patras
Patras, Greece

Laparoendoscopic single site surgery (LESS) nephrectomy is considered a technically challenging operation which limits the broader application of the technique. As every LESS operation, LESS nephrectomy is based on the concept that reducing abdominal ports, port related morbidity is diminished and a superior cosmetic result than multiport laparoscopy is provided. A nearly scareless outcome is evident in most of the cases, given that the single access is usually established and postoperatively hidid within the umbilicus or other natural orifices (e.g vagina). The advantages of LESS over conventional laparoscopy have not been clearly elucidated. Yet, worldwide experience with the technique is constantly expanding. In experienced laparoscopic centers, equivalent perioperative and oncological results to conventional laparoscopy have been documented for LESS radical, partial and donor nephrectomy. Additionally, expanding experience in single site surgery has provided tools such as transvaginal access, needlescopic instruments and robot assistance that can aid LESS nephrectomy and enhance its efficiency without compromising any of its advantages. A mix of these techniques with LESS could ease the stiff learning curve of the second and benefit not only its performance but the incorporation of LESS as a standard practice for nephrectomy in the near future as well.

Laparoscopic Pyeloplasty in children

Holger Till

Director, Department of
Pediatric Surgery
University of Leipzig
Leipzig, Germany

The PUJO (pelvi-ureteric junction obstruction) represents the most common cause for congenital hydronephrosis (Fefer 2006). The indication for a surgical correction is mainly based on renal function tests such as a MAG-III scintigraphy. In cases of severe obstruction the gold standard for an operation remains the Anderson-Hynes pyeloplasty, because it allows for success rates of up to 90% (Jarret 2004). Today, not the technique of pyeloplasty, but rather the access to the kidney remains a matter of vivid discussions. Since the first description of a laparoscopic pyeloplasty in adults by Schuessler in 1993, the minimal invasive approach has gained increasing popularity in children as well (Peters 1995). Meanwhile the transperitoneal and retroperitoneal access have been established in paediatrics (El-Ghoneimi 2003). Both have their pros and cons, especially when it comes to the reconstruction of the anastomosis in a very small space (Valla 2009). In any case the laparoscope allowed for magnified presentation of the PUJO and meticulous suturing.

The present literature presents many studies about the feasibility and the urological success rate of minimal invasive pyeloplasty (Ansari 2008; Szavay 2010), even in children younger than 1 year of age (Metzelder 2006). Moreover, they convey distinct advantages for the patients like reduced postoperative pain, shorter length of hospital stay and improved cosmesis. Unfortunately, most of these studies in children were longitudinal, observational trials without control groups or randomization so that the level of evidence remained limited. Additionally, in some reports the mean operating times seemed longer for the MIS group, while a few other were quite comparable (Cascio 2007).

In recent years robotic pyeloplasty has been advocated even in children. The protagonists pointed out that the robot allowed for a more subtle suturing (Chan 2010) and shorter operating time. Critics argued about higher costs and the size of the machine in contrast to 3mm standard laparoscopic instruments. With Laparo-endoscopic single-site surgery (LESS) entering the stage this discussion will certainly continue even in paediatric urology (Caione 2010).

Nowadays the minimal invasive pyeloplasty has achieved a high level of efficacy and safety in children and should be considered as the technique of choice in experienced hands.

Robot assisted Laparoscopic Pyeloplasty

Harrie Beerlage

Department of Urology

Jeroen Bosch Hospital

Hertogenbosch, The Netherlands

Since the first report on robot assisted laparoscopic pyeloplasty in 2002 over 80 publications on this subject have been published. Most are case reports or descriptions of technical refinements but also a number of trials have been reported.

Most urologic surgeons use a transperitoneal 4 port approach : a camera port, two robotica ports and one assistant port. Usually a classical Anderson Heynes dismembered pyeloplasty is performed, duplicating the successful open approach. A retroperitoneal approach is also feasible, again with a 4 port configuration. More recently single port robotic pyeloplasty was reported and in the laboratory environment even a NOTES robotic pyeloplasty was performed.

In spite of difficult anatomy in horseshoe kidneys the plasty can be performed as well. In case of stones it is proven feasible and safe to remove the stones in the same procedure.

Most urologic surgeons use double J stenting of the anastomosis, however as in the pediatric urology some people advocate stentless pyeloplasty. In a retrospective study in 52 patients (35 with and 17 without a stent) no differences in final outcome were found between the groups although 2/17 needed secondary postoperative stenting.

The laparoscopic pyeloplasty has replaced the open procedure as the gold standard for ureteropelvic junction stenosis. In a retrospective of 172 patients the robotic approach (98) was compared with the conventional laparoscopic (74). No differences were found with respect to operating time, complications and longtime outcome on diuretic scintigraphy.

In another study prospectively comparing trans and retroperitoneal robotic pyeloplasty also no differences were found with respect to objective success of the procedure.

In conclusion : robotic pyeloplasty is feasible and with results comparable to the gold standard being laparoscopic pyeloplasty. There seems to be no difference between trans and retroperitoneal approach. Stentless pyeloplasty is an option and stones can be removed in the same procedure.

Small-incision access Retroperitoneoscopic Technique (SMART)

Jens Rassweiler, Ali Serdar Gözen, Giovannalberto Pini, Michael Schulze

Head of Department of Urology

SLK Kliniken Heilbronn

University of Heidelberg, Germany

In recent years Urology has been marked by a progressive research of minimal invasive approaches to reduce morbidity. Laparo-endoscopic single-site surgery (LESS) has occurred, mainly driven by the effort to reduce trauma and improve cosmetics. Although this approach progressively reduced invasiveness and postoperative scar evidence, the complexity of the procedure is increased. LESS proved not easy to be performed, additionally associated with a lack of triangulation and the need to manage instruments in a parallel fashion, resulting to difficulties in dissection and manipulation of tissues particularly in absence of adequate tools. Furthermore, until now the cosmetic superiority has not been proven objectively.

We are performing since April 2010 in our clinic small-incision access retroperitoneoscopic technique (SMART) procedures in our clinic. Briefly; we are creating the retroperitoneal space with a home-made 6-mm balloon-trocar. One 6-mm and two 3,5-mm trocars are used for the 5-mm 30° telescope and for both 3-mm working instruments in order to reduce the invasiveness of laparoscopy and preserving also the triangulation and thereby maintaining the effectiveness and advantages of traditional laparoscopy.

We have analysed in an ongoing study prospectively peri- and post-operative data of our SMART series with special attention on scar assessment and postoperative pain. The cosmetic results after the operation were evaluated in an objective way based on a standardized assessment score system - the Patient and Observer Scar Assessment Scale – (POSAS). As a conclusion: SMART is feasible and effective and providing clearly better cosmetic results compared to standard retroperitoneoscopy.

Upper Tract Laparoscopy Nightmares

Alan McNeill

Consultant Urological Surgeon and Honorary Senior Lecturer
Department of Urology
Lothian University Hospitals
Edinburgh, Scotland

The objective of this presentation will be to demonstrate how prior preparation may help avoid any nightmares during upper tract laparoscopy, and provide some tips and tricks for managing problems if they do arise.

As a surgeon's experience of upper tract laparoscopy grows then his indications for a laparoscopic approach will increase, as will the technical challenge of the surgery. Consequently the technical expertise of the surgeon is challenged by these more difficult cases and the potential for unexpected complications increases. We will discuss how to anticipate and manage the difficulties associated with:

- I) Laparoscopy for large, higher stage RCC
- II) Cytoreductive laparoscopic radical nephrectomy
- III) Laparoscopic nephrectomy following infection – emphysematous pyelonephritis, XGP
- IV) Managing desmoplastic response associated with upper tract TCC

Unexpected haemorrhage is one of the most common causes for emergency conversion to open surgery. This may be associated with malfunction of haemostatic equipment such as staplers and clips, which is always a risk when these are being used (or misused) in laparoscopic surgery. We will discuss how to anticipate, avoid and manage unexpected bleeding.

Nightmares of Upper Urinary Tract Robotic Surgery

Giorgio Guazzoni

Professor and Chairman
Department of Urology
Università Vita e Salute
"Ville Turro" San Raffaele Hospital
Milan, Italy

The worldwide spread of robotic surgical machines in the last eight years, such as the Da Vinci system (Intuitive Surgical, Inc, Sunnyvale, CA, USA), has changed the way urologists approach laparoscopic procedures.

The seven degrees of freedom and three-dimensional vision are well known advantages of the Da Vinci System. More and more centres prefer to use robotic surgery over conventional laparoscopic surgery as technically difficult procedures are made easier. Pure laparoscopic experience is undoubtedly required and good training is needed especially for those assisting at the table. Moreover, unlike laparoscopic surgery, table-side surgical assistance plays an important role in establishing consistency during complex procedures.

Of course radical prostatectomy is the most common urological surgery using robotic technology at the present time. However, in the last few years robotics in urology is being routinely offered in institutions for upper urinary tract surgical procedures including the most common indications such as pyeloplasty and partial nephrectomy.

Ureteropelvic junction obstruction is not a common pathology and as a consequence complications occur due to the lack of knowledge of the procedure. An example of an alternative approach to pelvic junction is transmesocolic access. However, this could be dangerous and have some limitations especially in obese patients due to the presence of thicker mesentery. A crossing vessel is sometimes the cause of ureteropelvic junction obstruction and therefore requires extremely refined surgical skills to complete such an operation.

The extended indications for renal tumors less than 7 cm and the spreading use of minimally invasive surgery has increased the number of laparoscopic partial nephrectomies. Different authors have reported the higher risk of complications during laparoscopic partial nephrectomy compared to open surgery. Even if robot assisted partial nephrectomy could be easier than pure laparoscopic surgery, it should still be considered as a difficult procedure. The pedicle isolation represents one of the trickiest stages and good isolation is important to perform the procedure. An important role is related to the renorrhaphy. A good haemostasis and the absence of urinary fistula are both linked to excellent suturing skills.

In conclusion, upper urinary tract robotic assisted surgery is an extremely difficult type of surgery that requires tremendous skill and training.

Nightmares in Laparoendoscopic single site surgery (LESS)

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LESS was conceptualized and developed over the last 4 years in an attempt to further minimize the invasiveness of conventional laparoscopy. Despite unsolved challenges, LESS can be regarded as a new global trend in minimally invasive urologic surgery and it has significantly evolved, becoming a widely applicable technique.

A broad range of both extirpative and reconstructive procedures can be effectively done by LESS techniques. Overall, a non-inferiority of LESS as compared to standard laparoscopy has been demonstrated with a trend towards a benefit in terms of patient discomfort and cosmesis. Any new surgical technique requires a stringent assessment of its risks. Despite its promising outcomes so far, LESS requires an experienced laparoscopic surgeon to ensure a safe and successful procedure. When starting LESS, patient-selection criteria are expected to be stricter than with conventional laparoscopy. Sensitivity to the potential for complications is critical, and the threshold for conversion must be appropriately low. Disease features (ie, locally advanced disease requires more extensive dissection; abnormal anatomy requires extensive suturing) and patients features (ie, body habitus, BMI, comorbidity score, previous surgery or RT, personal preferences for better cosmetic outcome) are to be considered.

In a multi-institutional study looking at complications and rates of conversion from LESS to conventional laparoscopy at the time of upper tract urologic procedures, 125 patients were analyzed and conversion to conventional laparoscopy was necessary in 5.6% and complications occurred in 15.2% of patients undergoing LESS surgery. In a more recent multi-institutional worldwide experience, 1076 cases of LESS were included in the analysis. Overall conversion rate was 20.8%, being 15.8%, 4% and 1% to "reduced port" laparoscopy, conventional laparoscopy/robotic and open surgery, respectively. Intraoperative complication rate was 3.3% with need for conversion to open in 3 cases and laparoscopy in 5 cases. Postoperative complications were encountered in 9.5% of cases, mostly being low grade according to Dindo-Clavien. Based on currently available evidence, complications with LESS seem to be of similar nature and to occur with similar frequency to those experienced during standard laparoscopy. Undeniably, a solid laparoscopic surgical background is critical for a successful LESS and complications are unlikely only if stringent patient selection criteria are applied.

Friday, June 10th 2011

Friday

4:00—4:40 pm

Moderators

Peter Rimington
Peter Wiklund
Joachim Thüroff

Debates

Walter Artibani,
Konstantinos Konstantinidis

Cystectomy
Standard Laparoscopy vs. Robot Assisted
Laparoscopy vs. Open
Speaker Lap
Speaker Robot
Speaker Open

4:40—5:20 pm

Moderators

Roland Van Velthoven
Vipul Patel
Manfred Wirth

Joachim Thüroff, Tullio Sulser

Modifications of Radical Prostatectomy
Evidence based data or surgeon's wisdom
Speaker Lap
Speaker Robot
Speaker Open

5:20—6:00 pm

Moderators

Thierry Pièchaud
Jens Rassweiler
Michael Truß

Ingolf Türk, Panagiotis Kallidonis

General management of complications
during Radical Prostatectomy
Vascular injuries
Rectal injury
Anastomotic leakage

6:00 pm

Adjournment

Friday, June 10th 2011

Friday

Laparoscopic Cystectomy

Peter Rimington

Director of Urology

Eastbourne District General Hospital

Eastbourne, UK

Friday, June 10th 2011

Friday

Robot Assisted Laparoscopic Cystectomy

Peter Wiklund

Professor and Chairman

Dept. of Molecular Medicine and Surgery,

Section of Urology, Karolinska Institutet

Stockholm, Sweden

Gold Standard: Open Radical Cystectomy

Joachim Thüroff, Wolfgang Jäger

Professor and Chairman
Department of Urology
University of Mainz
Mainz, Germany

Open radical cystoprostatectomy is the gold standard for radical surgical treatment of bladder cancer. Laparoscopic and robotic-assisted laparoscopic surgical techniques of radical cystoprostatectomy aim at copying the principles of this reference standard. Hence, indications and surgical strategies of radical cystectomy are reviewed. Indications and limitations of different surgical strategies (“increasing radicality” or “reducing radicality”) are discussed for radical cystectomy in males and females and for pelvic and retroperitoneal lymph node dissection.

Decreasing radicality

Males: In males, indications, surgical technique and results of nerve-sparing radical cystoprostatectomy and prostate-sparing radical cystectomy are presented and discussed.

Females: In females, indications, surgical technique and results of urethral-sparing cystectomy, nerve-sparing, vaginal-sparing and uterus-sparing techniques are presented and discussed.

Lymph node dissection (LND): Reduction of the extent of lymph node dissection (limited vs. extended pelvic lymph node dissection [PLND], retroperitoneal lymph node dissection [RPLND]) are discussed in respect to nerve-sparing techniques and probability of skip lesions.

Increasing radicality

Males: Indications, surgical techniques and results of primary urethrectomy are presented and discussed.

Female: Indications, surgical techniques and results of primary urethrectomy, hysterectomy and anterior/complete vaginal resection are presented and discussed.

Lymph node dissection: Extent, templates and numbers of lymph nodes removed in pelvic ± retroperitoneal lymph node dissection are presented and discussed in regard to probability of skip lesions and results (CSS).

Comparison: Where available, comparative studies between open, laparoscopic and robotic-assisted laparoscopic radical cystectomy are discussed in regard to surgical strategies of reducing or increasing radicality, advantages/limitations and possible choices for urinary diversion.

Modifications of Laparoscopic Radical Prostatectomy

Roland Van Velthoven

Chairman Department of Urology
Service InterHospitalier d'Urologie
Institut Jules Bordet
Hospital Saint Pierre
Brussels, Belgium

Friday, June 10th 2011

Friday

Modifications of Robot Assisted Laparoscopic Radical Prostatectomy

Vipul Patel

Medical Director of Urologic Oncology,

Florida Hospital

Medical Director of Global Robotics Institute

Associate Prof of Urology

University of Central Florida

Florida, USA

Modifications of Open Radical Prostatectomy

Manfred Wirth

Professor and Chairman

Department of Urology

Universitätsklinikum "Carl Gustav Carus"

der Technischen Universität Dresden

Dresden, Germany

Friday, June 10th 2011

Friday

General management of complications during Radical Prostatectomy: Vascular Injuries

Thierry Pièchaud

Center of Urologic Laparoscopy

Clinique Saint Augustin

Bordeaux, France

Chairman of Urologic Courses

IRCAD-EITS, Strasbourg, France

General management of complications during Radical Prostatectomy: Rectal Injury

Jens Rassweiler

Head of Department of Urology
SLK Kliniken Heilbronn
University of Heidelberg, Germany

Background: Laparoscopic radical prostatectomy (LRP) represents an established treatment modality of localized prostate cancer.

Objective: To report standardized complication rates of LRP, to evaluate the development of complication rates over time and to show changes within the learning curves of laparoscopic surgeons.

Design, setting and participants: Standardized analysis of 2200 consecutive patients who underwent LRP between 1999 and 2008 at a single institution.

Intervention: LRP was performed using a transperitoneal (N=871) or extraperitoneal (N=1329) retrograde Heilbronn-technique. Five surgeons operated on 96% of patients.

Measurements: Complications were classified according to the modified Clavien-system. Total complication rates and changes over time were analysed. Three generations of surgeons were defined for evaluation of learning curves.

Results and limitations: Minor complications occurred in 21.7% (6.8% Clavien 1, 14.9% Clavien 2), anaemia requiring transfusion (10.4%) dominated. Early re-interventions were necessary in 6.7% (3.6% Clavien 3a, 1.5% Clavien 3b, 1.5% Clavien 4a, 0.1% Clavien 4b). Late Clavien 3b complications occurred in 4.7%, most of them were anastomotic strictures. Mortality was 0.1% (Clavien 5). There was a significant decrease in overall complication rates over time resulting predominantly from decreasing Clavien 1-2 events. Learning curves of third-generation surgeons plateaued earlier compared to the first generation (250 vs 700 cases). Limitation is that data concerning comorbidity were not included.

Conclusions: LRP is a safe procedure characterized by an acceptable profile of complications. Specifically, few major complications are reported. According to the complication rates, the learning curve of third generation surgeons is significantly shorter compared to first and second generation.

General management of complications during Radical Prostatectomy: Anastomotic Leakage

Michael Truß

Professor and Chairman
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There is no unanimously accepted method of categorisation of anastomotic leakage in the literature. Even though there are no strictly defined criteria, we have attempted a categorisation facilitating postoperative management of these patients. This classification is based on our scheme of catheter removal on the 5th postoperative day. We routinely perform a cystography prior to catheter removal. The final decision of catheter removal is certainly a clinical decision and should not be based strictly upon the recommended classification.

- Minor leak requiring 3 extra days of catheterisation
- Minor leak requiring an extra week of catheterisation.
- Major leak requiring insertion of mono J catheters and minimum of two weeks catheterisation.
- Major leak after dislocation of the catheter.
- Major leak requiring reintervention.

If the urine output through the urethral catheter is less than the output of the drain for more than 48 hours, then reintervention and reformation of the anastomosis should be considered. The reintervention is performed endoscopically (laparoscopically). Normal cystographies as well as the different cystographies depicting the various types of anastomotic leakages are demonstrated.

