

running behind the IVC medially, and then inferiorly passing anterior to the IVC. He underwent robotic repair of retrocaval ureter. The patient was positioned in left lateral decubitus. We used 5 ports; 12 mm camera port at right paraumbilical, 2 robotic 8 mm ports (one at subcostal, one between right iliac fossa and camera port), 5 mm port at right iliac fossa and lastly the assistant 10 mm port at infraumbilicus. The ascending colon was reflected medially to visualize the distended renal pelvis and IVC. Transection was done at the proximal ureter and the retrocaval ureter was transposed anterior to the IVC. Uretero-ureterostomy was performed with 3/0 monocryl suture. Before completing the anastomosis, a 6 Fr JJ stent was inserted antegradely. Finally a Redivac drain was inserted before the robot was undocked.

Results: The total operative time was 240 min with minimal blood loss. The patient recovered well and was discharged on day 2 post-operation. The stent was removed 6 weeks later and he remained well on follow up. The histopathology report of the transected ureter did not show fibrosis or chronic inflammation.

Conclusion: The role of minimally invasive surgery has expanded considerably in urology. Robotic-assisted laparoscopic surgery overcomes the technical difficulty encountered in traditional laparoscopy. In this case, robotic surgery is feasible and safe to perform the procedure without complications.

VID-05

Zero ischaemia robotic partial nephrectomy for hilar tumour

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Introduction: The advent of nephron-sparing surgery has allowed preservation of precious residual renal function for patients presenting with localised renal tumours. Zero-ischaemia partial nephrectomy is the ideal approach, however hilar tumours remains technically challenging even in the age of robotic-assisted surgery. Herein we detail the technique and outcome of our Robotic Partial Nephrectomy (RPN) in a hilar tumour.

Materials and Methods: 26 patients underwent RPN in Sarawak General Hospital. Mean postoperative follow up duration

was 28 months. Our index patient was a 54-year-old hypertensive with pre-morbid eGFR of 82 mL/min/m² who had an anterior hilar tumour 5 cm in size and RENAL nephrometry score of 10x.

Results: RPN was successful in all cases with zero conversion to radical or open surgery. Mean tumour size was 4 cm (2.5–6.1) and RENAL nephrometry score was 8. Mean operative time was 222 min (80–350) with an average of 20.5 min of warm ischaemia time (0–40) and blood loss of 407 mL (50–1500). Two zero-ischaemia RPN were performed. The mean post-operative hospital stay was 4.7 days (2–13). One patient (3.8%) had positive surgical margins with no recurrence on follow up CT imaging. Paradoxical improvement in mean eGFR was seen postoperatively - 73.4 (37–125) vs 65.0 (39–116) mL/min/1.73 m² and is adversely related to ischaemia time >30 min ($P = 0.002$). Three patients had postoperative complications (Clavien 3a). There was duality of blood supply from both segmental arteries in our index patient, which were selectively ligated. Console time was 350 min and total blood loss was 700 mL. Post-operative hospitalisation length was 5 days with no post-operative complication. Absolute change in eGFR was -2.0 while surgical margin was tumour free.

Conclusion: Zero-ischaemia RPN for hilar tumour is feasible and can be safely performed to preserve renal function. Randomised trials to study the benefit to this effect should be performed

VID-06

Anastomotic urethroplasty for penile urethral stricture: Approaches to avoid chordee formation

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Introduction: Transperineal anastomotic urethroplasty has become the gold standard surgical procedure for traumatic urethral stricture. Despite the successful rate of maintaining urethral patency of more than 90%, the challenge of performing this procedure for penile urethra strictures is the formation of chordee. We are reporting a case of traumatic penile urethra

stricture, which was successfully treated with anastomotic urethroplasty without developing chordee.

Case Report: A 30-year-old man was attacked by a buffalo sustaining degloving injury of his scrotum and penis. Emergency surgery was performed for debridement and control of bleeding where we found a non-salvageable right testis and complete transection of the urethra with a significant defect within the penile shaft. A suprapubic catheter was inserted and the wound was dressed until it completely healed with scar tissue. Gradually, the separated urethral ends fistulated at the wound with proximal opening at left-lateral 3 cm from base of penis and distal opening at mid-ventral aspect, 1.5 cm superior-medial from the proximal opening. Sixteen months later, he underwent transperineal anastomotic urethroplasty. The procedure began with mobilizing the entire length of the urethra until the distal fistula opening. Next, the corporeal body was separated followed by inferior pubectomy. The distal fistulated urethral opening was mobilized circumferentially until adequate length was achieved for anastomosis. Finally, a tunnel was created underneath the penile scar and both ends of urethra were anastomosed. Post-operatively, patient recovered well and was able to demonstrate straight erection.

Conclusion: Tunneling underneath scar tissue may offer an option to avoid chordee formation in anastomotic urethroplasty for penile urethra stricture.

VID-07

Laparoscopic resection of a patent urachus

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Introduction: A patent urachus results from failure of the foetal allantois to involute into the median umbilical ligament, and presents with urine discharge from the umbilicus as well as recurrent urinary tract infections. Definitive management of this condition involves complete resection of the urachal tube, which may be performed via open or laparoscopic approaches. We report a case of successful laparoscopic resection of a patent urachus at our centre.

Case Report: Our patient is a 23 year-old male who presented with urine discharge