

short laparotomy. For the remaining 12, the LRC was associated with a one-sided nephroureterectomy (which was always preceded in flank position before own RC), followed by a laparoscopic ureterocutaneous anastomosis. Conversion was not necessary. Severe complications occurred in 3, i.e. 7.9 % (2x Clavien IIIb - wound re-suture, reintroduction of stents and 1x V - pulmonary embolism death). In the entire 246 RC set, IIIb-V was 58 (23.6%). Long-term oncological results have not yet been evaluated.

Video: Laparoscopic radical cystectomy with extracorporeal ureteroileostomy: Trendelenburg position, 5 ports (10, 12 and 3x 5 mm), 3D imaging, surgeon and 2 assistants. The Ligasure Blunt tip 5 mm® sealing tool is used for both pelvic lymphadenectomy and its own RC. Only in male is sometimes used on the Santorini plexus V-Loc® 90 stitch. The peritoneum is opened, the ureters released and transacted above the urinary bladder, followed by lymphadenectomy along the

external iliac vessels and the obturator bundle. Division of the pedicles of the urinary bladder. In females as part of anterior exenteration resected the front wall of the vagina is resected below under the bladder. From the subsequent paraumbilical minilaparotomy (about 7 cm) the specimen is extracted and an appendectomy and ureteroileostomy are performed.

Conclusion: Laparoscopic RC with extracorporeal ureteroileostomy is feasible and has become a standard for reducing the incidence of postoperative complications in selected (about one third) patients (BMI to 33, less advanced tumours). It does not require any special equipment (ports, sealing tool, staplers and extensive use of clips are not necessary). An condition is an experienced laparoscopic team is necessary.

KEY WORDS

Tumor of urinary bladder, cystectomy, laparoscopy.

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