1. **9.00** Robotic versus laparoscopic adrenalectomy for pheochromocytoma: step-by-step technique of first Irish experience
   **Stefanie Croghan**, Catherine Nix, Silvu David, Nauman Nabi, Cristian Albu, Daniel McNicholas, Girish Nama, Muhammad Akram, Subhasis Giri
   Department of Urology and Robotic Surgery, University Hospital Limerick, St Nessan's Road, Dooradoyle, Limerick, V94 F858, Ireland.

2. **9.10** First experience of trans oral endoscopic thyroidectomy – vestibular approach (TOETVA) in Ireland & UK at Cork University Hospital
   **Zeeshan Razzaq**, Peter O'Leary, Mudassar Majeed, Michael Hanrahan, Hamid Mustafa, Mohammed Abdalla, Fara Hassan Khawaja, Fuad Aftab, Akbar Amin Achakzai, Henry Paul Redmond
   Department of General Surgery, Cork University Hospital, Wilton, Cork, Ireland.

3. **9.20** Not all plain sailing, lessons in laparoscopic cholecystectomy from a 6 month rotation
   **Robert Fleck**, Peadar Waters, Gerry McEntee, John Conneely
   Department of Hepatobiliary Surgery, Mater Misericordiae University Hospital, Eccles Street, Dublin, D07 R2WY, Ireland.

4. **9.30** Early Experience of laparoscopic retro-peritoneoscopic adrenalectomies at Cork University Hospital
   **Mudassar Majeed**, Zeeshan Razzaq, Akbar Amin Achakzai, Michael Hanrahan, Hamid Mustafa, Christopher O’ Hare, Peter O’ Leary, Fara Hassan Khawaja, Fuad Aftab, Henry Paul Redmond
   Department of General Surgery, Cork University Hospital, Wilton, County Cork, Republic of Ireland.

5. **9.40** Instructional video: 30 degree laparoscope
   **Edward James Murphy**, Mohammad Faraz Khan, Liam Angus Devane, Babak Meshkat, Ronan Ambrose Cahill
   Department of Surgery, Mater Misericordiae University Hospital, Eccles Street, Dublin, D07 R2WY, Ireland.

6. **9.50** “Route to the middle colics”
   **Mohammad Faraz Khan**, Edward Murphy, Emma Dunne, Ronan Cahill
   Department of Colorectal Surgery, Mater Misericordiae University Hospital, Eccles Street, Dublin, R2WY, Ireland.
7. **10.00** Laparoscopic guided transversus abdominis plane (TAP) block for abdominal surgery
   
   Liam Aengus Devane, Edward James Murphy, Mohammad Faraz Khan, Conan Liam McCaul, Ronan Ambrose Cahill,
   
   1Department of Colorectal Surgery, Mater Misericordiae University Hospital, Eccles Street, Dublin, D07 R2WY, Ireland
   
   2Department of Anaesthesia, Mater Misericordiae University Hospital, Eccles Street, Dublin, D07 R2WY, Ireland
   
   3Surgical Specialties, School of Medicine, University College Dublin, Belfield Downs, Dublin, D14 YH57

8. **10.10** Robotic and laparoscopic partial nephrectomy: a matched-pair comparison of single surgeon’s Irish experience
   
   Jody Khan, Silvu David, Nauman Nabi, Cris Albu, Sarah Norton, Stefanie Croghan, Girish Nama, Muhammad Akram, Subhas Giri
   
   Department of Surgery, University Hospital Limerick, St Nessan’s Road, Dooradoyle, Limerick, V94 F858, Ireland

9. **10.20** Laparoscopic proctocolectomy with intersphincteric resection and transanal total mesorectal excision
   
   Cillian Clancy, Tayyaub Mansoor, John Burke
   
   Department of Colorectal Surgery, Beaumont Hospital, Beaumont Road, Beaumont, Dublin 9, Ireland

10. **10.30** Expanding indications of robotic urological surgeries beyond prostate—Irish experience with a dual-console Xi da Vinci surgical system
    
    Cristian Albu, Jody Khan, Stefanie Croghan, Silvu David, Nauman Nabi, Daniel McNicholas, Girish Nama, Muhammad Akram, Subhas Giri
    
    Department of Urology and Robotic Surgery, University Hospital Limerick, St Nessan’s Road, Dooradoyle, Limerick, V94 F858, Ireland

11. **10.40** Da Vinci Xi Robotic partial nephrectomy for complex renal mass
    
    Stefanie Croghan, Jody Khan, Nauman Nabi, Silvu David, Cris Albu, Sarah Norton, Daniel McNicholas, Girish Nama, Muhammad Akram, Subhas Giri
    
    Department of Urology, University Hospital Limerick, St Nessan’s Road, Dooradoyle, Limerick, V94 F858, Ireland

12. **10.50** Robotic assisted ultra-low anterior resection with intersphincteric dissection post neoadjuvant chemoradiotherapy for rectal cancer
    
    Awais Aamir, Tara Connolly, Helen Mohan, Shoaib Ashfaq, Dara Walsh, John Calvin Coffey, Colin Peirce
    
    Department of Colorectal Surgery, University Hospital Limerick, St Nessan’s Road, Dooradoyle, Limerick, V94 F858, Ireland
AB001. 217. Robotic versus laparoscopic adrenalectomy for pheochromocytoma: step-by-step technique of first Irish experience

Stefanie Croghan, Catherine Nix, Silvu David, Nauman Nabi, Cristian Albu, Daniel McNicholas, Girish Nama, Muhammad Akram, Subhasis Giri

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Background: Recent evidence supports the use of minimally invasive robotic surgery for the surgical management of adrenal masses. Our aim is to describe a current step-by-step technique of robotic adrenalectomy (RA) and to compare its outcomes with those of laparoscopic adrenalectomy (LA).

Methods: Twenty patients underwent adrenalectomy using minimally invasive approach, of these four patients underwent LA and one RA for pheochromocytoma. Data were retrospectively reviewed from a prospectively maintained database. The main steps of our current surgical technique for RA are described in the video lecture: patient positioning, port placement, and robot docking; exposure of the adrenal gland; identification and control of the adrenal vein; circumferential dissection of the adrenal gland; and specimen retrieval and closure. Demographic parameters and main surgical outcomes were assessed.

Results: In both groups, skin-to-skin operative time, estimated blood loss less, and intra-operative hemodynamic parameters were similar. There was no conversion to open. There was no morbidity or mortality in either group. Operation time was longer by 20 min in the RA. Blood loss and length of stay were similar.

Conclusions: To our knowledge, this is the first Irish experience comparing robotic versus laparoscopic resection of pheochromocytoma. Our results show that the robotic approach is similar to the laparoscopic regarding safety and efficacy. The standardization of each surgical step optimizes the RA procedure.

Keywords: Phaeochromocytoma; adrenal; robotic; laparoscopic; adrenalectomy

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AB002. 76. First experience of trans oral endoscopic thyroidectomy—vestibular approach (TOETVA) in Ireland & UK at Cork University Hospital

Zeeshan Razzaq, Peter O’Leary, Mudassar Majeed, Michael Hanrahan, Hamid Mustafa, Mohammed Abdalla, Fara Hassan Khawaja, Fuaad Aftab, Akbar Amin Achakzai, Henry Paul Redmond

Department of General Surgery, Cork University Hospital, Wilton, Cork, Ireland

Background: Many patients requiring thyroidectomy are concerned regarding scar caused by incision in the neck. Various techniques of minimally invasive thyroidectomy, including endoscopic and robotic thyroidectomy, have been developed to address this issue. TOETVA has been successfully used in the recent past worldwide, with few complications and excellent results. Moreover, recent literature comparing TOETVA with open thyroidectomy has confirmed that the TOETVA is performed as safely as traditional open thyroidectomy, requires only conventional laparoscopic instruments, and avoids incisional scars; thus, the approach may be an option for selected patients.

Methods: We present a case series of two young female patients presenting with neck lumps and requesting scar less neck surgeries for cosmetic concerns. First lady aged 23 presented with a 3 cm benign left thyroid lobe nodule with cosmetic concerns. Second lady aged 56 presented with a 2.8 cm, indeterminate right thyroid lobe nodule. Both were booked for trans oral hemithyroidectomy (TOETVA) after explaining risks, benefits & alternatives.

Results: Both patients had un-eventful surgeries and were discharged home on day 1 post op. Both had mild post op bruising that settled completely at 2 weeks post op. Second patient had mild paraesthesia at chin at day 1 that settled subsequently at day 7 likely representing neuropraxia. There was no hoarseness of voice or post op hypocalcaemia in either of them. Histology was benign for both patients who were subsequently discharged from clinic at week 4 post op.

Conclusions: TOETVA is a safe alternative minimally invasive procedure for the management of benign & malignant thyroid lesions in suitable patients.

Keywords: Thyroid nodule; TOETVA; trans oral thyroidectomy

doi: 10.21037/map.2019.AB002

AB003. 89. Not all plain sailing, lessons in laparoscopic cholecystectomy from a 6-month rotation

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Background: Cholecystectomy is one of the most commonly performed abdominal surgeries in the Western world and over 90% are performed laparoscopically. It is also one of the first laparoscopic procedures that surgical trainees will be allowed to undertake. Despite being an extremely effective and well tolerated procedure, serious complications still occur in 2.6% of cases.

Methods: Every laparoscopic procedure at our institution is routinely recorded. We searched the laparoscopic cholecystectomy recordings from a 6-month period from January–July 2018 and selected 6 videos that we felt highlighted some important lessons that should be considered when performing this procedure.

Results: The first video shows the management of a difficult dissection when traditional techniques either fail or are not appropriate. The second video demonstrates how to manage an arterial bleed in the setting of equipment malfunction. The third video explores different options available when presented with an obstructed gallbladder that is difficult to grasp or retract. The fourth video is of a gallbladder volvulus. The fifth video illustrates the management of an intra-operative bile leak. The final video is an example of a near miss in the setting of aberrant biliary anatomy.

Conclusions: Laparoscopic cholecystectomy is well established as the gold standard treatment for most gall bladder disease and is a procedure frequently undertaken by surgical trainees. Whilst often straightforward, complications, unusual findings and abnormal anatomy are not uncommon and should always be considered when attempting the procedure.

Keywords: Cholecystectomy; laparoscopic; biliary

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AB004. 96. Early experience of laparoscopic retroperitoneoscopic adrenalectomies at Cork University Hospital

Mudassar Majeed, Zeeshan Razzaq, Akbar Amin Achakzai, Michael Hanrahan, Hamid Mustafa, Christopher O’Hare, Peter O’Leary, Fara Hassan Khawaja, Fuad Aftab, Henry Paul Redmond

Department of General Surgery, Cork University Hospital, Wilton, Cork, Ireland

Background: Adrenalectomies were traditionally performed by open technique. However more recently, laparoscopic trans-peritoneal and laparoscopic retroperitoneal approaches are gaining popularity. Laparoscopic approach has the advantages of less post-operative pain, fewer wound site problems and above all reduced length of hospital stay. The aim of this retrospective study was to examine the characteristics of all retroperitoneoscopic adrenalectomies done at Cork University Hospital (CUH).

Methods: All cases of retroperitoneoscopic adrenalectomies done at CUH since April 2017 were retrospectively reviewed. Patient demographics, diagnosis, surgical approach, length of hospital stay, histology and all documented complications were evaluated.

Results: There were 9 retroperitoneoscopic adrenalectomies performed at CUH since April 2017 when this technique was first commenced. Seven patients (78%) were females. Average age was 54 years (range, 23–78 years). Five surgeries (56%) were left sided. There were no conversions to open surgery. Average size of adrenal lesion on imaging was 3.7 cm (range, 1.7–5.1 cm). Pre-operative diagnosis was pheochromocytoma [3], non-functioning adenoma [3], Cushing’s syndrome [2] and Conn’s syndrome [1]. The mean length of post-operative stay was 2.3 days (range, 2–3 days). There were no post-operative complications. Final pathology showed adrenal cortical adenoma [5], benign pheochromocytoma [3] and adrenal schwannoma [1]. There was no mortality and no recurrence seen.

Conclusions: Retroperitoneoscopic adrenalectomy is a safe procedure and in our setting was primarily performed for pheochromocytoma and non-functioning adenomas. It is associated with fewer complications, shorter hospital stay and has a low conversion to open rate.

Keywords: Adrenalectomy; adrenal adenoma; pheochromocytoma

doi: 10.21037/map.2019.AB004

AB005. 140. Instructional video: 30-degree laparoscope

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Background: The use of laparoscopy for minimally invasive surgery is widely established. There are several angled lens laparoscopes available that increase the range of operative views. Proficient use of an angled lens laparoscope requires experience and training, however difficulty can arise with communication and direction between surgeon and assistant.

Methods: We have developed an instructional video on the use of a 30-degree camera which can be applied to all angled lens laparoscopes. The principles are demonstrated with the aid of a laparoscopic box and live intra-operative recordings. The training system proposed is based on a clock face representing the position of the light source. A zero-degree camera is used for comparison.

Results: Using external images of the operator and laparoscope alongside the camera images we are able to explain the correlation between laparoscopic movements and the associated camera image.

Conclusions: This instructional video is openly available for surgical training. The clock face training can be used to improve instruction and communication intraoperatively.

Keywords: Minimally invasive surgery (MIS); laparoscopy; video

doi: 10.21037/map.2019.AB005

Cite this abstract as: Murphy EJ, Khan MF, Devane LA, Meshkat B, Cahill RA. Instructional video: 30-degree laparoscope. Mesentery Peritoneum 2019;3:AB005.
**AB006. 152. Route to the middle colics**

Mohammad Faraz Khan, Edward Murphy, Emma Dunne, Ronan Cahill

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**Background:** For right sided colonic cancers, it is imperative to obtain an optimum mesocolic specimen with a high tie of the associated vascular pedicles. This necessitates meticulous dissection and step wise approach to the overall operation. Identification and skeletonisation of middle colic artery and its branches do not often follow a standardised approach.

**Methods:** Live video recording of elective laparoscopic cases, demonstrating approach and technique to allow for complete mesocolic excision with central vascular ligation, for right sided colonic tumours. Exposure of the trunk of the middle colic and its right branch is emphasised.

**Results:** Sections from our sampled videos illustrating the operative steps. Ileocolic pedicle dissection, superior mesenteric vein identification (SMV) caudal to cranial approach to root of middle colic vessels. This allows for clear identification and address of the middle colic vessel in a manner that is reproducible and teachable.

**Conclusions:** A step wise approach and appreciation of relevant anatomy is key, especially of the vascular supply to the right colon. Video recording aids in allowing the team to demonstrate the pertinent steps and also encourage self critique and improvement of required surgical skills in order to perform an appropriate operative procedure.

**Keywords:** Complete mesocolic excision; high tie; middle colic

doi: 10.21037/map.2019.AB006

*Cite this abstract as:* Khan MF, Murphy E, Dunne E, Cahill R. Route to the middle colics. Mesentery Peritoneum 2019;3:AB006.
AB007. 165. Laparoscopic guided transversus abdominis plane (TAP) block for abdominal surgery

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Abstract: Pain control is integral to enhanced recovery after surgery (ERAS) protocols. Transversus abdominis plane (TAP) blocks are frequently used as part of a multimodal anaesthetic regimen however the availability of theatre time, technical expertise and ultrasound equipment can be limiting factors. Drawing together the best published evidence, we demonstrate how and why the TAP block can be placed laparoscopically at conclusion of laparoscopic surgery. Surface anatomy is used to define the subcostal and lateral TAP block injection sites bilaterally. Using a 10 cm Braun Stimuplex needle, 10 mL of 0.25% levobupivacaine (2.5 mg/mL) is injected into the TAP plane at each site (40 mL total or max 2 mg/kg). The needle is advanced under vision until it tents the peritoneal surface and is then retracted slightly into the TAP plane. On injection ‘Doyle’s internal bulge sign’ can be seen as the transversus abdominis is pushed internally. As this method is performed under direct vision with laparoscopic equipment already in use it can result in faster, easier and more controlled delivery of local anaesthetic. Direct visualisation with a laparoscope is especially beneficial in obese patients where safe needle insertion using a blind technique or ultrasound guidance can be difficult.

Keywords: Laparoscopic; transversus abdominis plane block (TAP block)

doi: 10.21037/map.2019.AB007

Cite this abstract as: Devane LA, Murphy EJ, Khan MF, McCaul CL, Cahill RA. Laparoscopic guided transversus abdominis plane (TAP) block for abdominal surgery. Mesentery Peritoneum 2019;3:AB007.
AB008. 197. Robotic and laparoscopic partial nephrectomy: a matched-pair comparison of single surgeon’s Irish experience

Jody Khan, Silvu David, Nauman Nabi, Cris Albu, Sarah Norton, Stefanie Croghan, Girish Nama, Muhammad Akram, Subhasis Giri

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Background: To evaluate the relative advantages of robotic-assisted partial nephrectomy (RPN), using a matched-pair analysis, with laparoscopic PN (LPN) and to describe our technique in step by step approach.

Methods: Between July 2016 and October 2018, 40 patients had RPN for renal tumour; the outcomes were compared retrospectively with 40 matched patients who had LPN. Patients were matched for age, gender, American Society of Anesthesiologists score, tumour side, size and location. Outcomes measures included operative time, estimated blood loss, warm ischaemia time (WIT), serum creatinine before and after surgery, length of hospital stay, transfusion rate, operative and 30-day complications. We describe our technique of RPN and LPN in video lecture.

Results: There was no significant difference between the 2 cohorts with respect to patient age, ASA score, preoperative serum creatinine or tumor size. Median operative time for RPN was 180 vs. 220 minutes for LPN (P<0.05). There was significant difference with respect to median warm ischemia time (20 vs. 25 minutes, P<0.05), median length of hospital stay (4 vs. 6 day). Two patients in the LPN group had urine leak managed conservatively and two required blood transfusion.

Conclusions: RPN is more favourable than LPN in terms of shorter total operation time, warm ischemia time, shorter length of hospital stay and less complications.

Keywords: Robotic partial nephrectomy; laparoscopic

doi: 10.21037/map.2019.AB008

AB009. 14. Laparoscopic proctocolectomy with intersphincteric resection and transanal total mesorectal excision

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Background: Emerging techniques and approaches in colorectal surgery can be applied in select patients to optimise perioperative outcomes.

Methods: We report our approach in a 44-year-old male with a cT3N2 mid rectal tumour and innumerable polyps due to MYH-associated polyposis. He underwent neoadjuvant long course chemoradiotherapy.

Results: We performed a laparoscopic total colectomy with a medial to lateral approach for high vascular ligation. The ileum was divided using an endoGIAä and later matured as an end ileostomy by enlarging an existing 12 mm port in the right iliac fossa. Mesorectal excision was performed laparoscopically to the mid rectum and the remainder completed trans-anally. An intersphincteric dissection was initiated with the aid of a Lonestar retractorä, a Gelpoint Pathä port was placed and an Airsealä device was used to establish a pneumopelvis. A total mesorectal excision was completed and the colon and rectum removed transanally. The final histology revealed an R0 resection of an ypT3N1b tumour with minimal response to chemoradiotherapy. The patient was discharged day 5 post-operatively.

Conclusions: A combined laparoscopic and transanal total mesorectal excision (TME) mobilisation with an intersphincteric dissection is a useful approach in cases where a proctocolectomy is necessary and reconstruction is not required.

Keywords: Intersphincteric resection; transanal total mesorectal excision (TME); proctocolectomy

doi: 10.21037/map.2019.AB009

Cite this abstract as: Clancy C, Mansoor T, Burke J. Laparoscopic proctocolectomy with intersphincteric resection and transanal total mesorectal excision. Mesentery Peritoneum 2019;3:AB009.
AB010. 215. Expanding indications of robotic urological surgeries beyond prostate—Irish experience with a dual-console Xi da Vinci surgical system

Cristian Albu, Jody Khan, Stefanie Croghan, Silvu David, Nauman Nabi, Daniel McNicholas, Girish Nama, Muhammad Akram, Subhasi Giri

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Background: The landscape of the surgical management of urologic conditions has dramatically changed over the past 2 decades, both for benign and malignant pathologies. The benefits of robotically-assisted radical prostatectomy have been well documented but little has been published regarding the benefits of robotically-assisted urologic procedures beyond radical prostatectomy. We report our experience with a variety of non-prostatic urological procedures including first radical cystectomy for bladder cancer performed in Ireland utilizing a dual-console da Vinci Xi surgical system.

Methods: We analysed our robotically-assisted urology cases from a prospectively maintained data base. Data were collected by independent third party. The dual-console Da Vinci Xi® Surgical Robot (Intuitive Surgical Ltd., CA, USA) was utilized for all cases. The type and number of procedures were recorded, along with patient demographics, length of stay, morbidities and mortalities as per the Clavien-Dindo classification. We present our video in the lecture.

Results: A total of 103 urological procedures were performed so far in just over 24 months. The median patient age was 62. The median ASA score was 2 and postop length of stay was 4 days. There were 40 partial nephrectomies, 35 nephrectomies, 12 Anderson-Hynes pyeloplasties, 9 adrenalectomies, 5 nephron-ureterectomy with bladder cuff, 1 marsupialisation of renal cyst and 1 radical cystectomy with total abdominal hysterectomy, bilateral salpingo-oophorectomy and bilateral pelvic lymph node dissection. The median estimated blood loss was less than 100 m. Three procedure was converted to open. Four patients experienced Clavien-Dindo grade 2 complications. There were no grade 3 or more complications.

Conclusions: Our study shows that robotic-assisted surgery can be safely implemented beyond radical prostatectomy to a wide spectrum of urological conditions requiring surgical intervention including complex procedure such as radical cystectomy with total abdominal hysterectomy, bilateral salpingo-oophorectomy, and bilateral pelvic lymph-node dissection and beyond.

Keywords: Robotic surgery; radical cystectomy; pyeloplasty; adrenalectomy

doi: 10.21037/map.2019.AB010

AB011. 216. Da Vinci Xi robotic partial nephrectomy for complex renal mass

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Background: Complex renal mass may preclude a minimally invasive approach to nephron sparing surgery in some patients. We describe our technique with da Vinci Xi robotic platform, illustrated with video, of robotic partial nephrectomy for challenging renal tumours, including large, hilar and endophytic tumours.

Methods: Between July 2016 and October 2018, 15 out of 40 patients were found to have complex renal mass with RENAL nephrometry score of 9 or more. Patient details were collected for age, gender, American Society of Anesthesiologists score, tumour side, number, size and location. Outcomes measures included operative time, estimated blood loss, warm ischaemia time (WIT), serum creatinine before and after surgery, length of hospital stay, transfusion rate, operative and 30-day complications.

We describe our technique of robotic-assisted partial nephrectomy (RPN) for complex cases in video lecture.

Results: Twelve out of 15 patients with complex tumour underwent Xi robotic partial nephrectomy successfully without complications. Three patients required open conversion after complete hilar dissection. Hilar clamping was utilized with a mean warm ischemia time of 30 minutes (range, 25–45 minutes). Mean blood loss was 250 mL (range, 150–450 mL). Histopathology confirmed clear cell renal cell carcinoma (n=8), papillary renal cell cancer (n=4), chromophobe renal cell carcinoma (n=2) and hybrid oncocytic tumour (n=1). All patients had negative surgical margins. Mean index tumour size was 3.5 cm (range, 2.5–7 cm). Mean hospital stay was 4 days.

Conclusions: Xi robotic platform facilitates tumour resection and renal reconstruction for challenging cases, offering a minimally invasive surgical option for select patients with complex tumours who might otherwise require open surgery. Robotic partial nephrectomy is a safe and feasible approach for select patients with complex renal tumours.

Keywords: Kidney cancer; laparoscopy; partial nephrectomy; robotics; technique

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AB012. Robotic assisted ultra-low anterior resection with intersphincteric dissection post neoadjuvant chemoradiotherapy for rectal cancer

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Abstract: Conventional laparoscopic approaches for rectal cancer have been widely adopted, however, technical limitations are increasingly being addressed by robotic platforms. Considered safe and feasible, robotic surgery potentially overcomes some of the shortcomings of laparoscopic surgery, especially for low rectal tumours. The Da Vinci Xi robot provides the operating surgeon with three-dimensional vision, 7° of wrist-like motion, tremor filtering, motion scaling, better ergonomics, and less fatigue thereby making it an ideal tool for operating deep within the pelvis. A 29-year-old female, post ovarian transposition and neoadjuvant chemoradiotherapy for a locally advanced low rectal cancer underwent robotic assisted ultra-low anterior resection (RULAR), robotic intersphincteric dissection, transanal specimen extraction and handsewn coloanal anastomosis. The main steps of the technique for RULAR are demonstrated in the video: patient positioning, port placement and robot docking; identification and division of the inferior mesenteric artery and vein; splenic flexure mobilization, total mesorectal excision, intersphincteric dissection, specimen retrieval and coloanal anastomosis. The patient had an uneventful postoperative course and was discharged on day 6. Pathological analysis demonstrated a ypT3N0 tumour with negative resection margins. Robotic approach to colorectal cancer has the potential to address some of the technical and ergonomic issues associated with laparoscopic surgery without compromising oncological outcome. The Da Vinci Xi robotic platform is a contemporary tool that can be safely utilized for pelvic colorectal surgery. This platform has become an important part of the colorectal surgery field.

Keywords: Breast cancer (BC); screening; surveillance

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