A laparoscopic surgical view of the prostate gland, showing its reddish, lobulated surface and surrounding structures. The text is overlaid on this image.

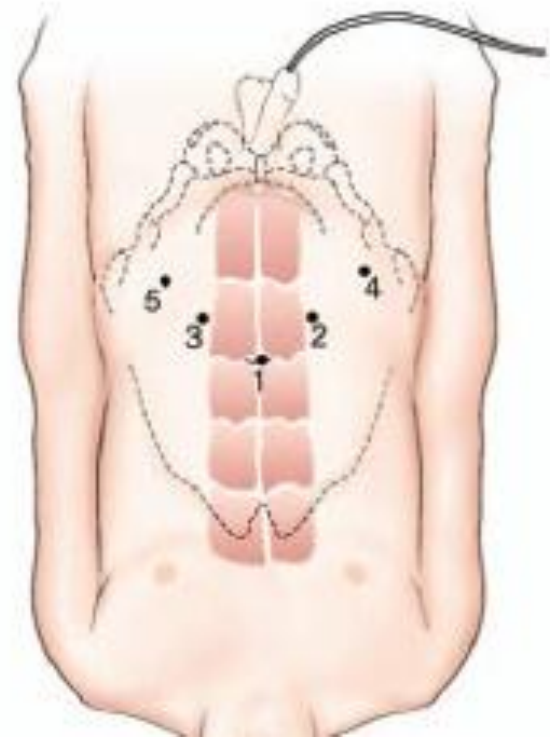
Laparoscopic and Robotic Radical Prostatectomy Tips and Tricks Case Discussion

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Case 1

- 69 years old - PSA: 7ng/dl
- T1c, Gleason 6 CaP
- TRUS volume: 30 ml
- PMh: none
- PSh: TURP 5 years ago, 35gr, TURP syndrome



Questions

- Would you perform cystoscopy preoperatively?
- Would you insert double pig-tail stents preoperatively?

pl

p

Questions

An anatomical illustration showing a retrograde approach for a transperitoneal or extraperitoneal approach. The image is a close-up of the abdominal cavity, showing the retroperitoneum. A line labeled 'pl' points to the posterior layer of the peritoneum, and a line labeled 'p' points to the retroperitoneum. The illustration is in a reddish-brown color scheme, typical of medical textbooks.

- Which do you prefer transperitoneal or extraperitoneal approach?
- Any tips for the retrograde or the antegrade technique?

Questions

- How do you identify the bladder neck?
- How about apical dissection?
- Your thoughts about robotic surgery?

pl

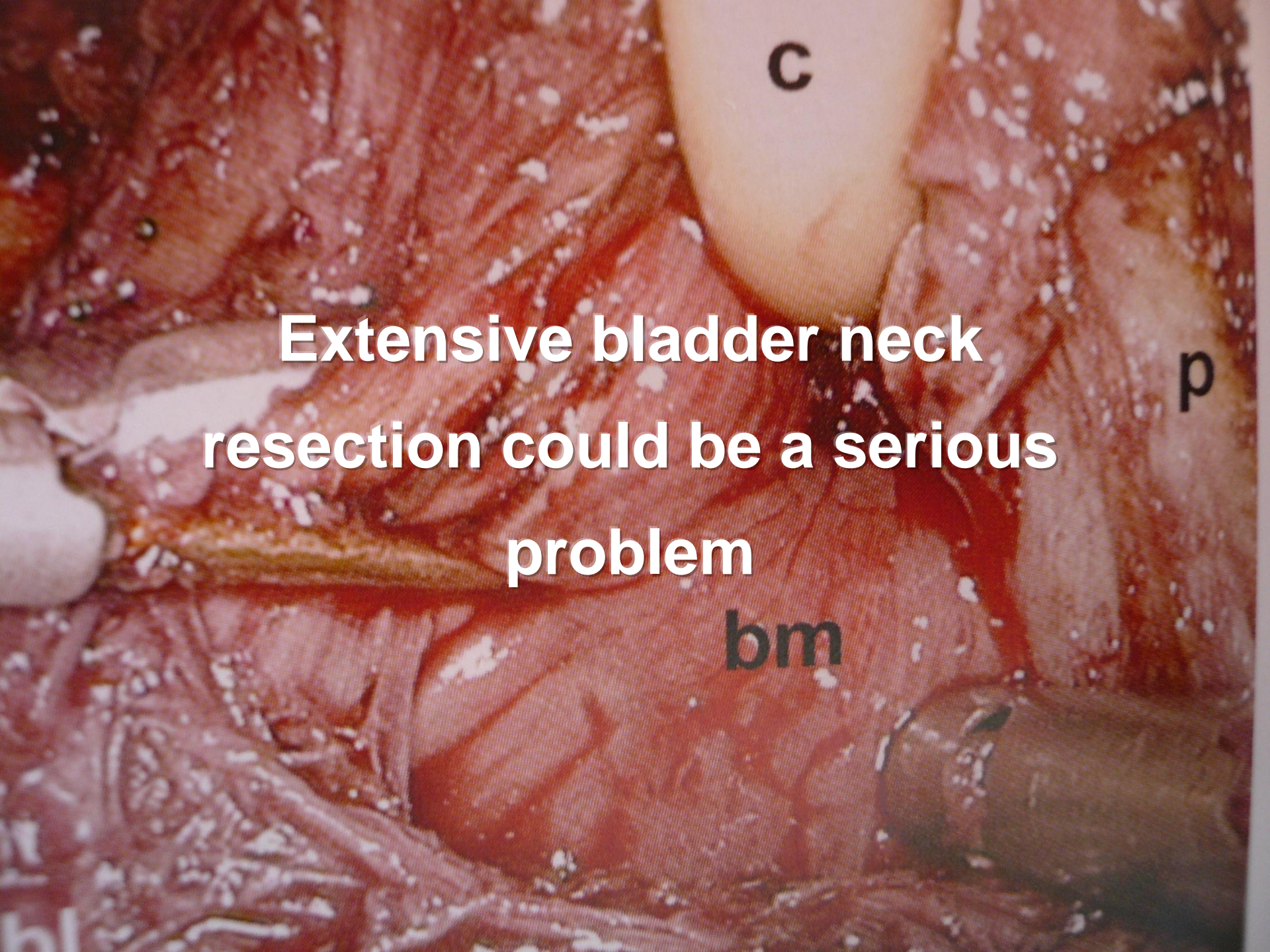
p



•Prior-TURP makes case more challenging

The image is an intraoperative photograph showing a surgical field. A retractor system is used to hold back muscle and soft tissue, providing a clear view of the underlying structures. A long, thin surgical instrument is visible, likely a resectoscope. The tissue is reddish and vascularized. Several black dashed lines are drawn on the image to indicate specific anatomical features or surgical planes. The labels 'p' and 'bn' are placed near these lines.

bn



**Extensive bladder neck
resection could be a serious
problem**

This anatomical illustration shows a cross-section of the bladder neck and surrounding structures. The label 'c' is positioned at the top, pointing to the ureter. The label 'p' is on the right side, pointing to the pelvic wall. The label 'bm' is in the lower center, pointing to the bladder muscle. The text 'Extensive bladder neck resection could be a serious problem' is overlaid in the center of the image.

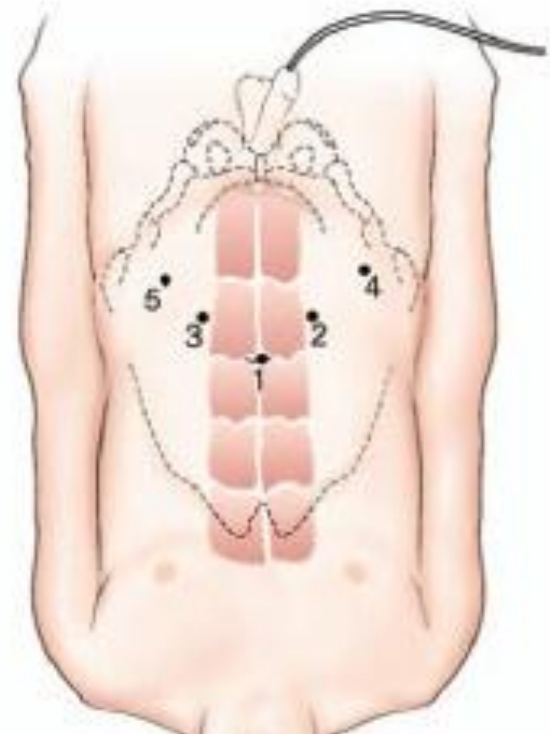
An intraoperative photograph showing a surgical field. A large, pale, elongated structure, likely the ureter, is visible in the upper center and is labeled with a black 'c'. To the right, a smaller, more rounded structure is labeled with a black 'p'. The surrounding tissue is reddish-brown and vascularized. The text 'Preoperative identification of UOs and catheterization is recommended' is overlaid in white. Below this, the text 'Antegrade technique is commenced' is also overlaid in white.

**Preoperative identification
of UOs and catheterization
is recommended**

**Antegrade technique is
commenced**

Case 2

- 71 years old - PSA: 10ng/dl
- T1c Gleason 6 CaP
- TRUS volume: 180 ml, large middle lobe, asymmetric apex
- PMh: CAD on medical therapy, BMI 29Kg/m², potent
- PSh: none



Questions

- Is this case ideal for laparoscopic or robotic radical prostatectomy?
- Transperitoneal or Retroperitoneal approach?
- Retrograde or antegrade technique?

pl

p

Questions

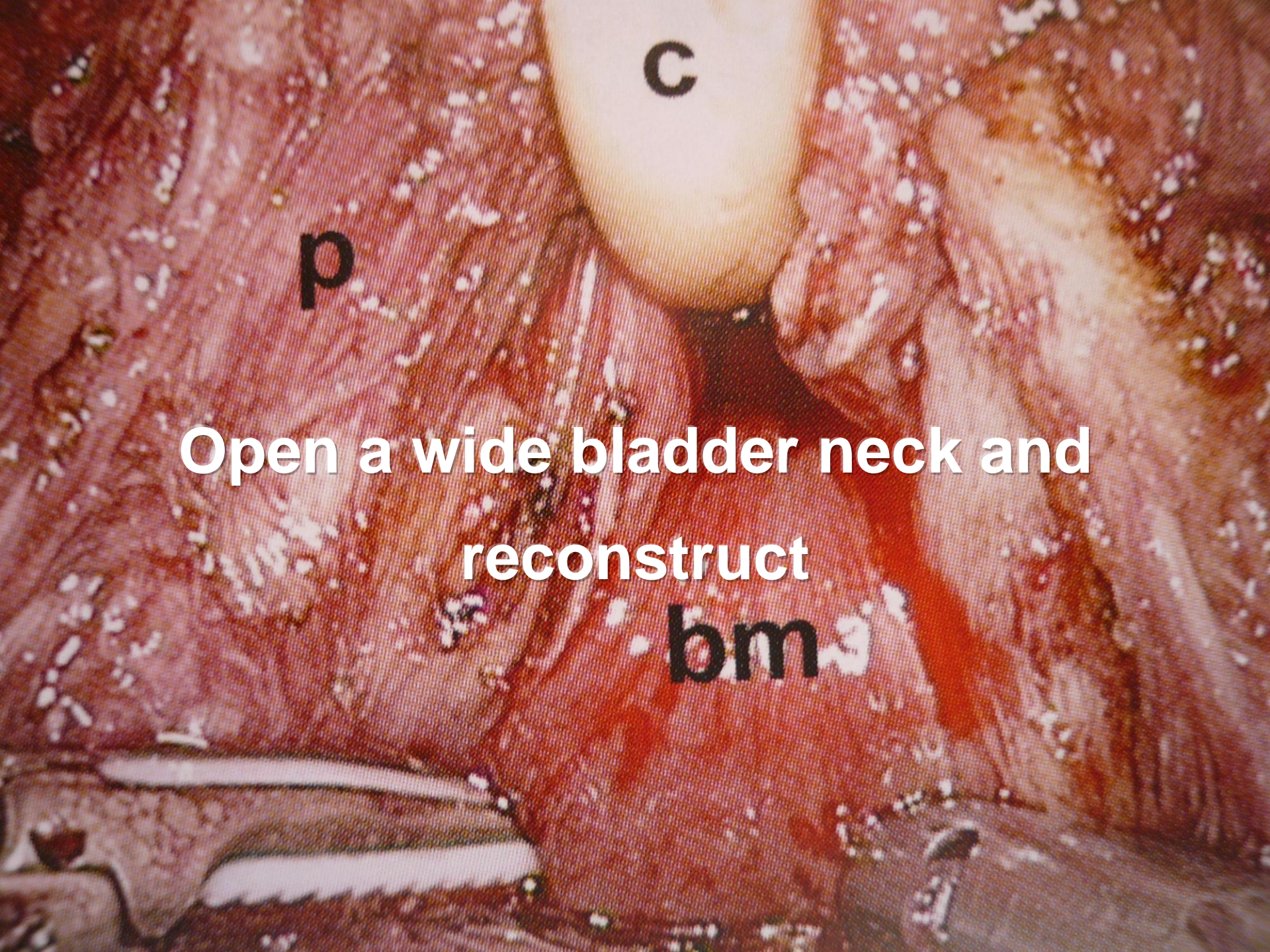
The background is a surgical photograph of a prostatectomy. It shows the prostate gland and surrounding structures. A line points from the label 'pl' in the top right to the lateral pedicle. Another line points from the label 'p' in the bottom center to the prostatic urethra. The image is in color, showing various shades of red and pink from the surgical field.

- How would you preserve the bladder neck?
- How do you transect the lateral pedicle and mobilize the neurovascular bundles during a nerve-sparing prostatectomy?
- How do you perform the apical dissection and maximize urethral length?

An intraoperative photograph showing a large, reddish, lobulated prostate gland. A surgical instrument is visible on the left side of the frame. The text 'ml' is overlaid on the upper right portion of the gland.

ml

**Prostates larger than 150gr
should be managed only by
experienced surgeons**



c

p

**Open a wide bladder neck and
reconstruct
bm**

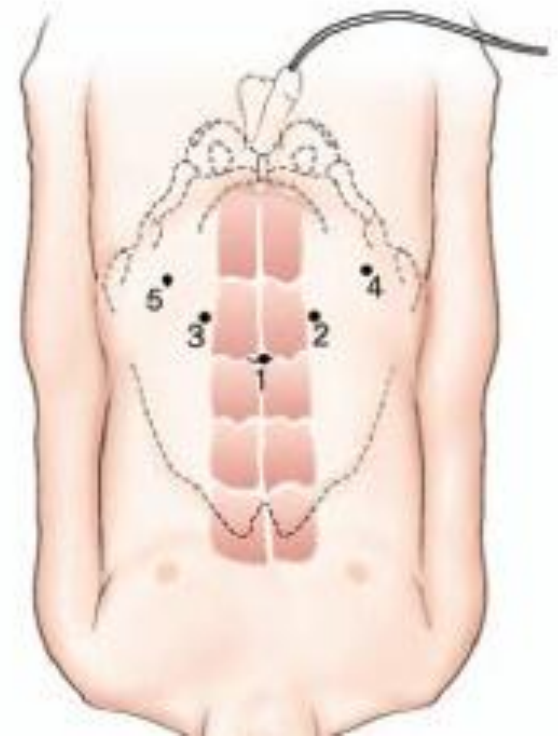
An intraoperative photograph showing a surgical dissection. A large, pale, elongated structure, likely the prostate, is visible at the top center, labeled with a black 'C'. Below it, a dark, vascularized area is labeled with a black 'P'. The surrounding tissue is reddish-brown and highly vascularized. The text 'Posterior apical dissection is demanding (ascending and descending technique)' is overlaid in white. At the bottom, a surgical instrument is visible, and the text 'TRUS should help with the asymmetry' is overlaid in white.

**Posterior apical dissection is
demanding (ascending and
descending technique)**

**TRUS should help with the
asymmetry**

Case 3

- 68 years old - PSA: 6ng/dl
- T2, Gleason 7 CaP
- TRUS volume: 65 ml
- PMh: CAD, Hypertension, Diabetes on medical therapy, ASA score II-III, BMI 47Kg/m²
- PSh: none



Questions

- How often are you confronted with such a patient?
- How do you see robotic prostatectomy to be different from pure laparoscopic prostatectomy?
- Transperitoneal or extraperitoneal approach?

pl

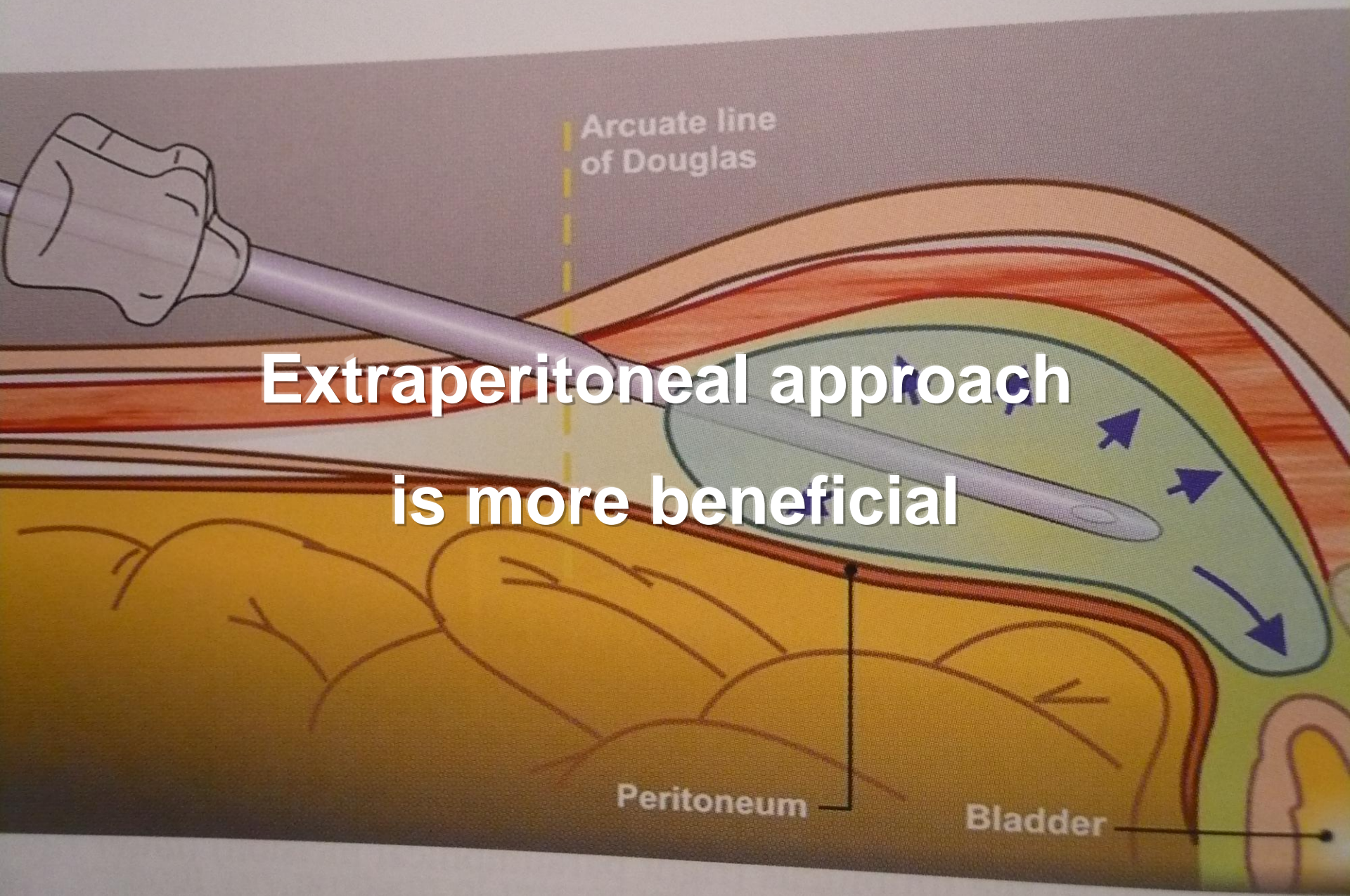
p

Questions

- What are the optimal angles of port placement?
- Same for robotic surgery?
- In case the bladder does not “reach” the apex what would you recommend?



**Obese patients are challenging
but may benefit from laparoscopic
surgery**



Arcuate line
of Douglas

**Extraperitoneal approach
is more beneficial**

Peritoneum

Bladder

- 
- The image shows a diagram of a human back, likely for a minimally invasive surgical approach. Several dark, curved lines are drawn on the skin, representing planned incision sites. Four arrows are also present: one at the top right pointing downwards, one in the center pointing upwards, one on the right side pointing upwards, and one at the bottom left pointing upwards. These arrows likely indicate the direction of incision or the orientation of the patient.
- The trocars should be inserted 1-3cm caudally
 - Increase Trendelburg

An intraoperative photograph showing a laparoscopic view of the abdominal cavity. The image displays various abdominal organs, including what appears to be the liver and stomach, with a surgical instrument visible on the left. A white circular marker with the letter 'C' is placed on the lower right portion of the image. The text is overlaid in white on the image.

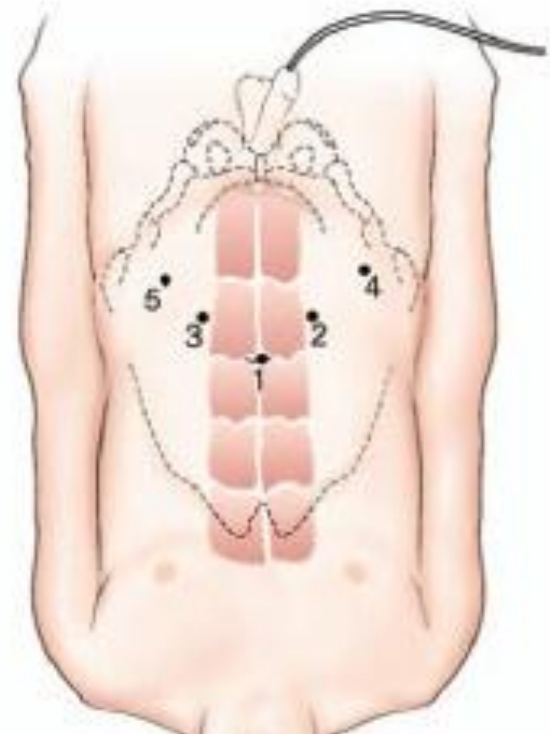
Reduce pneumoperitoneum,

Mobilize bladder

Convert to transperitoneal?

Case 4

- 65 years old - PSA: 5 ng/dl
- T1c, Gleason 6 CaP
- TRUS volume: 50 ml
- PMh: None
- PSh: 2 laparotomies for a perforated appendicitis 35ys ago, and a right TEP (or TAPP) hernioplasty 5 years ago



Questions

- Is this a reason for conversion to open surgery?
- Robotic, transperitoneal or extraperitoneal approach?
- Which is the optimal position of the trocars?

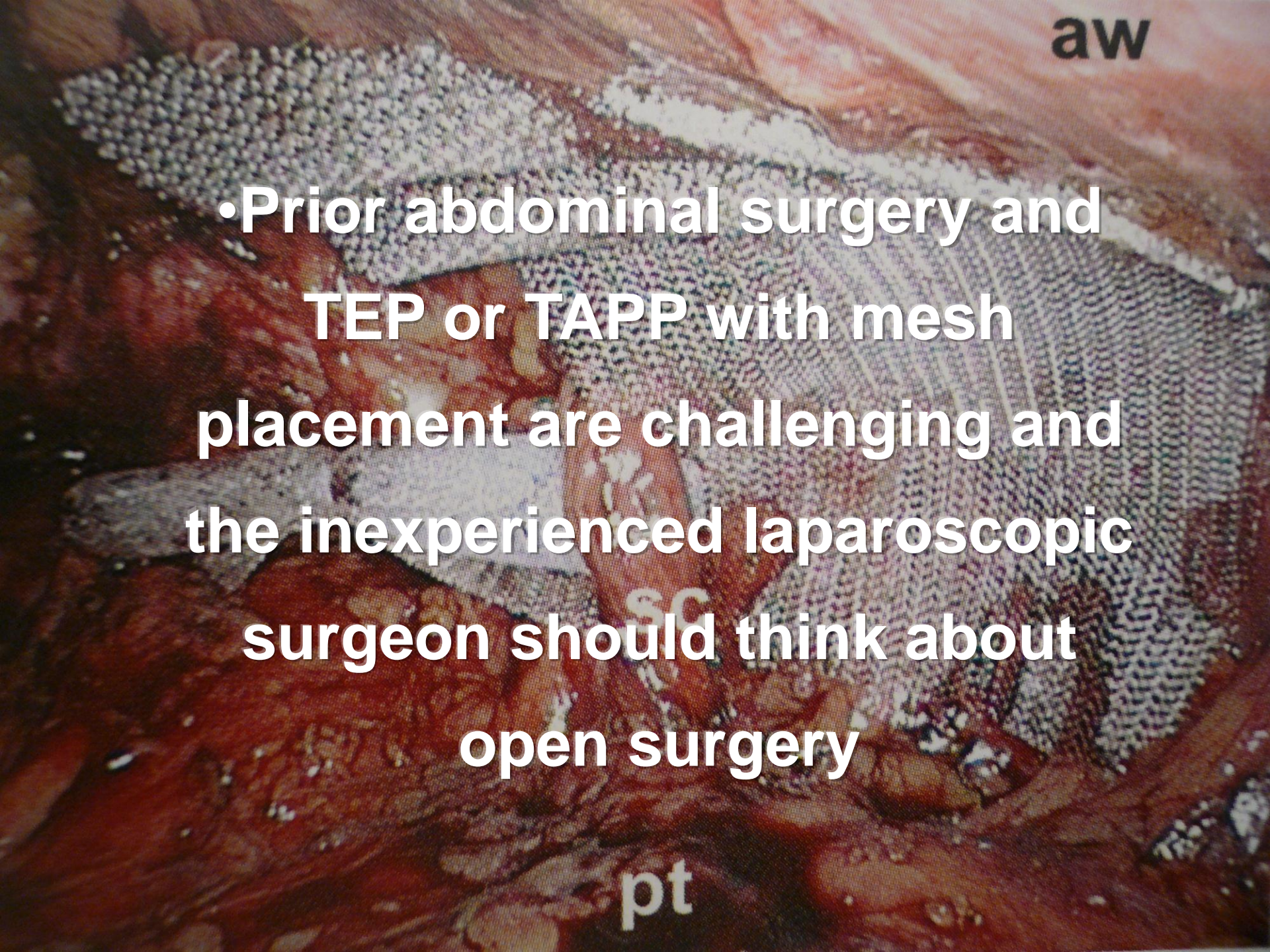
pl


p

Questions

A laparoscopic surgical view of the abdominal cavity. A white mesh is visible, partially covered by a translucent membrane. A black line points from the label 'pl' in the upper right to the mesh. Another label 'p' is located near the bottom center, pointing to a structure below the mesh. The background is a reddish, vascularized tissue.

- Which is the optimal position of the trocars?
- Is there a higher risk for bladder injury?
- What about lymphadenectomy at the site of the mesh?

- 
- An intraoperative photograph showing a surgical site. A large, white, woven mesh is visible, likely used for hernia repair. The mesh is partially covered by a layer of reddish-brown tissue. Several anatomical structures are labeled with white text: 'aw' in the top right, 'sc' in the center, and 'pt' at the bottom. The overall scene is dimly lit, typical of a surgical environment.
- Prior abdominal surgery and TEP or TAPP with mesh placement are challenging and the inexperienced laparoscopic surgeon should think about open surgery

A diagram of a human torso, likely a female, showing the abdominal area. The skin is a light brown color. There are several dark, curved lines drawn across the abdomen, representing adhesions. These lines are marked with small 'x' symbols. A vertical line runs down the center of the abdomen. A horizontal line is drawn across the upper abdomen, just below the chest. A curved line is drawn across the lower abdomen. The text 'The trocars should be adopted away from the adhesions that are present' is overlaid on the diagram in white, bold, sans-serif font. The text is centered and spans across the middle of the image.

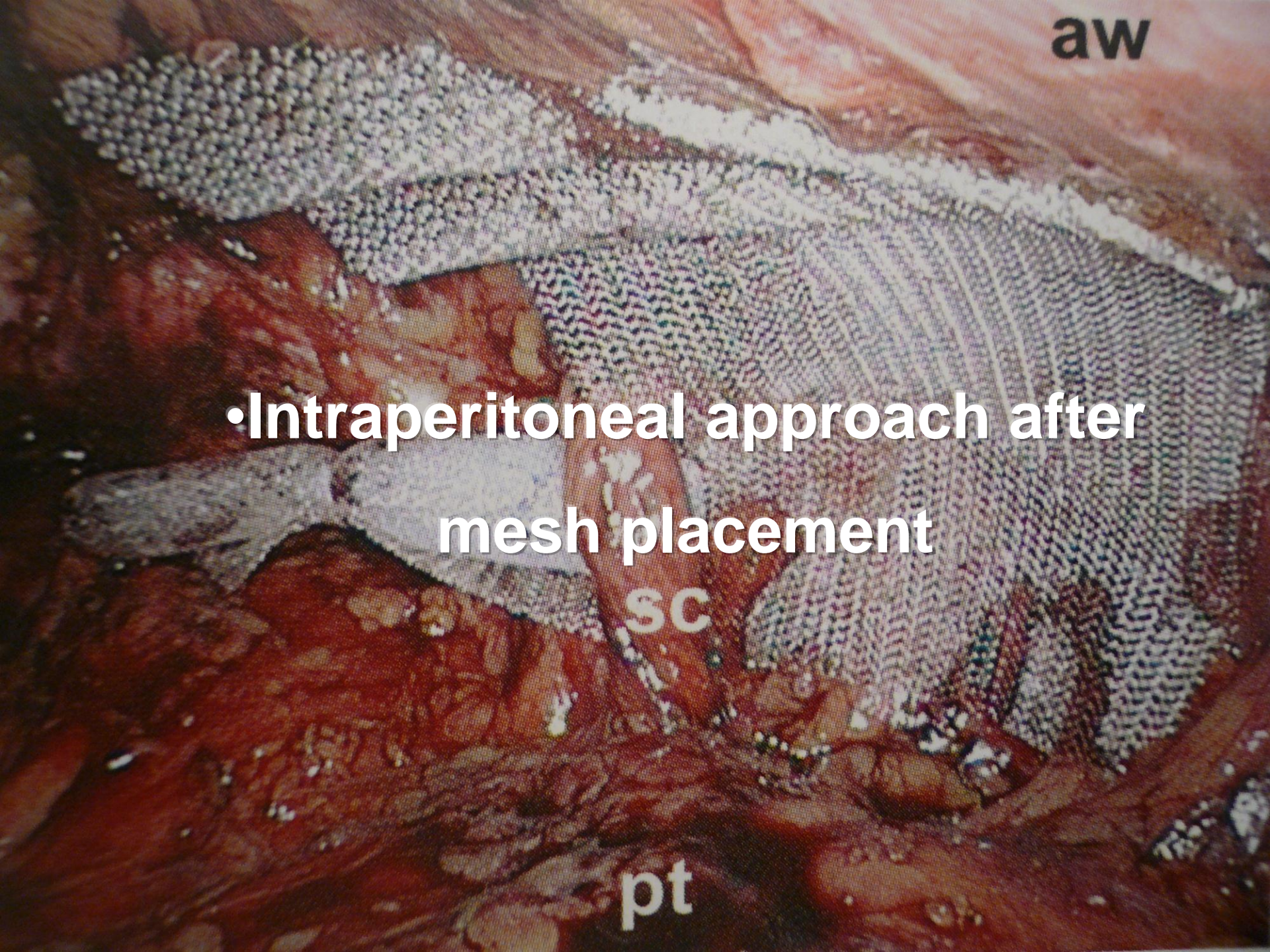
**The trocars should be adopted
away from the adhesions that
are present**

aw

- Intraperitoneal approach after mesh placement

SC

pt



A photograph of a patient's back during a surgical procedure. A large, irregularly shaped area of the back is covered by a blue surgical drape. A small, circular incision is visible on the lower back, with a small red mark above it. A white surgical drape is visible on the left side of the patient's back. The patient is lying on a green surface.

**Extraperitoneal approach
after abdominal surgery**

An intraoperative photograph showing a surgical site. A large, reddish, fleshy mass is visible, likely a tumor or lymph node. A surgical mesh is implanted over the site. A surgical instrument, possibly a stapler or stapler, is visible in the lower left corner, with its jaws open and positioned near the mesh. The background is a deep red color, possibly blood or the underlying tissue.

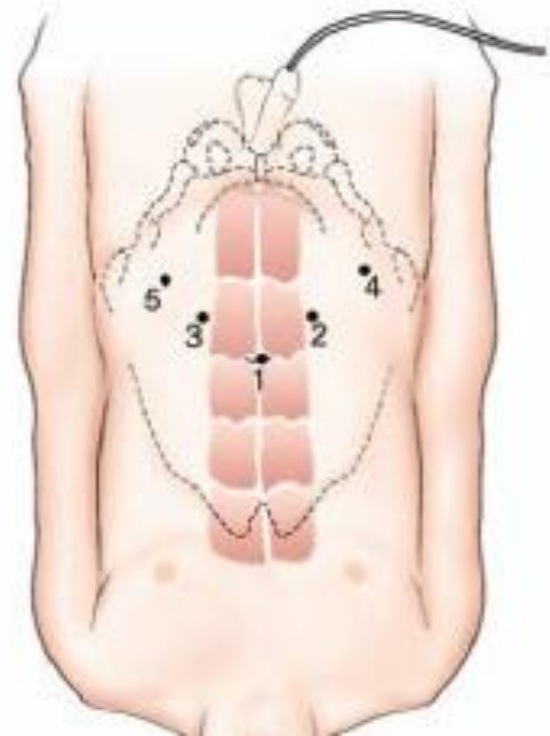
a

**Extremely difficult or
impossible lymphadenectomy
on the site of the mesh**

gn

Case 5

- 65 years old
- PSA: 5 ng/dl
- T1c clinical stage CaP
- Laparoscopic
Extraperitoneal Descending
Radical Prostatectomy



Questions

An anatomical illustration of a surgical dissection, likely of the abdominal cavity. The image shows various tissues, including what appears to be the peritoneum and underlying structures. A label 'pl' with a line pointing to a specific area is visible in the upper right. Another label 'p' is visible near the bottom center. The overall color palette is reddish-brown, typical of medical illustrations.

- What would you do if a rupture of the peritoneum during dissection of the extraperitoneal space occurs?
- What causes the problem (predisposing factors)?
- Are there any measures to increase the space?

Answers

- Continue the operation
- Previous pelvic surgery (appendectomy, hernia repair)
- Muscle relaxation, “wider” window to the peritoneum

pl

p

Questions

- How would you stop Santorini plexus bleeding?
- What would you do when arterial bleeding occurs (coagulation or clipping or suturing)?
- How do you control bleeding from NV bundles?

pl

p

Answers

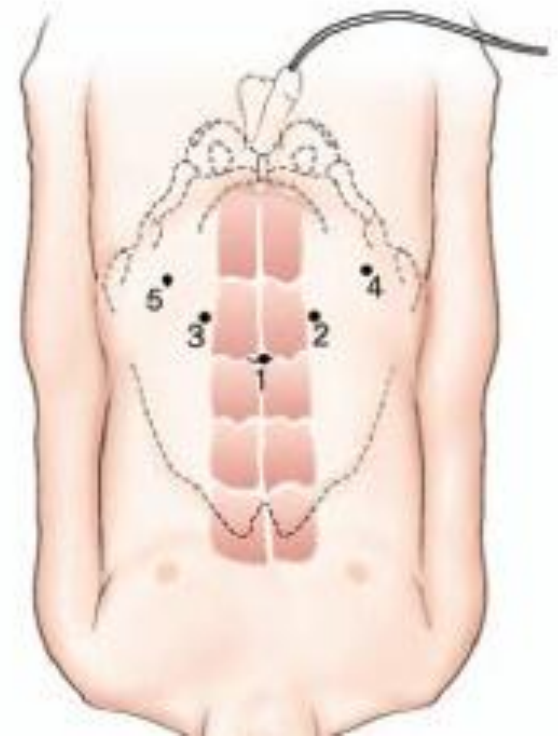
- Use all of them
- Increase pressure to 20mmHg, bipolar coagulation, additional suturing, divide ventral urethra-retract catheter
- Avoid coagulation, selective suturing, sealants

pl

p

Case 6

- 56 years old
- PSA: 5 ng/dl
- T1c clinical stage CaP
- Robotic Transperitoneal Prostatectomy



Questions

- At which steps the ureter can be damaged?
- How would manage a ureteral damage?

pl

p

Answers

- LND, VD dissection, Posterior BN dissection, during anastomosis
- Indigo carmine and furosemide, intraoperative catheterization, ureteral reconstruction, BN reconstruction at 6 o'clock

Questions

- At which steps the rectum can be injured?
- How would manage a rectal injury?

pl

p

Answers

- At the end of the procedure when dissecting the apex dorsally (prostatitis, fibrosis)
- Late thermal injury
- Intrarectal devices
- Endoscopic correction in two-layer suture line
- Parenteral nutrition for 6 days

An endoscopic surgical view showing a reddish, moist tissue field. A black line points from the label 'pl' in the upper right to a specific anatomical structure. Another label 'p' is visible near the bottom center. The text 'THANK YOU' is overlaid in the center.

THANK YOU

Recommended reading: Endoscopic Extraperitoneal
Radical Prostatectomy JU Stolzenburg Springer