

reflection, the renal artery is ligated and divided, the left renal vein is dissected on. The right colon reflection is performed, the right renal vein and vena cava is dissected. Safinsky clamp is placed on infrarenal vena cava, a bulldog clamp is placed on the right renal vein and a Safinsky clamp is placed on vena cava above the thrombus. Circular incision on vena cava at the level of left renal vein is performed and en block perifascial nephrectomy including the thrombus is done. The vena cava incision is repaired with a continuous 4-0 vascular suture. Extensive lymph node dissection is performed.

Conclusions: Out of more than 1305 RCC operated in our Department between 1975 – 2000, 142 cases have had caval extension. Using appropriate surgical technique, the patient's survival is almost similar to those without caval extension.

ORTHOTOPIC BLADDER SUBSTITUTION WITH DETUBULARIZED SIGMOID COLON

I. Sinescu, G. Gluck

*Center of Urological Surgery, Dialysis and Renal Transplantation
"Fundeni" Clinical Institute, Bucharest, ROMANIA*

Video

Introduction: The surgeons who performs substitution cystoplasty should know different techniques utilising the small bowel and sigmoid colon, depending of the local anatomic situation.

Materials and methods: A sigmoid colon segment of about 25 cm is isolated. The colic continuity is restored. The isolated segment is put under a "U" shape, it is detubularized and the arms of the "U" are sutured each to the other. The reservoir is anastomosed to the urethra. The urether implantation is performing according to Le Duc Carney modified technique and the pouch is closed.

Results: From a cohort of 51 patients, this type of cystoplasty have been performed to 23 cases (4 partial detubularized, 19 total detubularized). The postoperative evolution was a good one, continence was relatively good, there were no phenomena of vesico - urethral reflux. All the patients have had daily continence. 7 patients are incontinent during night time.

Conclusions: The sigmoid colon represents a technical variant for bladder substitution to be retained due to its pelvic position, a good vascularization, to easy restoring of the colic continuity, to the urodynamic qualities of the sigmoid bowel, etc.

RIGHT RCC WITH CAVO-CARDIAC TUMOR THROMBUS

Sinescu I., M. Hârza*, C. Gângu*, B. Șerbănescu*, C. Chibelean*, H. Moldovan***

**Department of Urology and Renal Transplantation,
Fundeni Clinical Institute, Bucharest, Romania*

***Cardiological Surgery Department,
Cardiology Institute "Prof.C.C. Iliescu", Bucharest, Romania*

Video

Introduction: One of the unique features of RCC is the frequent pattern of growth intraluminally into the renal venous circulation in extreme cases this growth may extend into the inferior vena cava with cephalad migration in the heart.

Material and method: It has been our experience that an anterior surgical approach through a subcostal and pararectal incision provides excellent exposure for performing radical nephrectomy. A second cardio-vascular team, through a median sternotomy, cannulated the ascending aorta and the right atrium and cardiopulmonary bypass is initiated. The tumor thrombus is gently removed from the IVC.

Results: In our department we performed more than 1305 radical nephrectomies for RCC. We have had 117 lateral or total IVC resection and in 8 cases we removed the thrombus from the right atrium.

Conclusions: This approach allows such thrombus to be removed completely in a controlled operative setting that provides excellent exposure and reduces the potential for massive blood loss or major vascular injury.