INTRODUCTION

The advantages of robotic surgery such as three-dimensional surgery and endo-wrist movement capability has canalized the urologists for different techniques for radical prostatectomy. The “Retzius sparing radical prostatectomy” was first defined by Galfano pointing out the advantages of complete intrafascial dissection, smaller surgical dissection and avoidance of pubovesical ligaments and Santorini plexus. They reported early return of continence and higher potency rates with this technique. Preventing of anterior structures in the space of Retzius may provide better continence rates. We also believe that better intrafascial dissection can be achieved by this technique providing better erection and continence rates.

PATIENT SELECTION

We only select low-risk patients according to D’Amico classification having prostates smaller than 50cc without a manifest median lobe.

SURGICAL TECHNIQUE

We perform our technique of robot assisted retzius sparing radical prostatectomy using the Da Vinci Xi robotic surgical system. (Intuitive Surgical, Sunnyvale, CA, USA)

The patient is placed lithotomy and Trendelenburg position of 30°. Using a Veress needle pneumoperitoneum is created. Transperitoneal approach is used with five arms, four 8 mm port (one camera and three robotic arms) and one 12 mm assistant port. (Port replacements Figure 1) 30° or 0° lens can be used according to the surgeon’s preference.

Operation is started with transvers incision of Douglas pouch just 2 cm above the rectum. Bilateral vasa deferantias and seminal vesicles are dissected. The denonvillier fascia is seperated in an antegrade direction till the apex of the prostate along the posterialateral side of prostate within the intrafascial plane. Lateral pedicles are dissected and clipped using titanium or...
hem-a-lock clips. (Figure 2) Peritoneum can be hanged with a suture to the anterior abdominal wall in order to make a good retraction and a good image. (Figure 3) After, basis of the prostate is separated from neurovascular bundles. (Figure 4)

Vesicoprostatic junction is identified, bladder neck is separated from prostate. (Figure 5) It is necessary to put marking sutures to bladder neck orifice in order to find well during anastamosis. (Figure 5) Just after anterior surface is isolated from Santorini plexus and lateral sides are bluntly dissected from bundles till urethra. (Figure 6) Urethra incised and the specimen is put in an endobag. (Figure 7)

The anastamosis is performed beginning from 12 o’clock position continuously with a silicone 18F foley catheter using a double needle suture. (Figure 8) After hemostasis a drain is placed and the peritoneum is closed. (Figure 9)

**TAKE HOME MESSAGES**

1. The advantages of this technique are preserving the fascias and neurovascular bundles via a real infracapsular dissection and minimal or no deal with dorsal vein complex.

2. The most disadvantage think is the vision as it is not the way we used to do.

3. There are no long term results but short term results show us a good continence rates and better erection rates.

4. Although some authors use this technique for low and intermediate risk groups, we think that it is better to use for low risk disease without a median lobe for small prostates. (<50 gr)

5. Although transperitoneal way is used, closing the peritoneum at the end can help to lower intraperitoneal postoperatif complications such as peritoneal irritation because of a leakage.
REFERENCES


