Once robotic cystectomy and bilateral extended pelvic lymph node dissection is completed, left ureter is moved to the right side through the tunnel constructed in the posterior of the sigmoid colon over the major vessels. Then both ureters are lifted up by holding from the sutures attached to the Hem-o-Lok clips placed at the distal edges of ureters using robotic Prograsp forceps coming into the abdomen on the left side (Figure 1). Both ureters are incised and spatulated longitudinally using robotic monopolar curved scissors (Figure 2). A Wallace type uretero-ureteral anastomosis is performed using a 4/0 Monocryl suture (20 mm, 1/2, circle, round needle). Sutures of the anastomosis are started at 6 o’clock at the bottom of the spatulation and direction is out to in of the right ureter, then in to out of the left ureter. Therefore, the knot stays outside (Figure 3). Then, again an out to in suture is passed through the right ureter and in this way the needle is placed inside again. A running suture is continued until the top of the spatulated ureters that joins both ureter in the middle creating a single opening and in this way posterior wall of the uretero-ureteral anastomosis is completed (Figure 4).

Afterwards ureteral stents (8F, 70 cm) are inserted in the midline through the abdominal wall by Seldinger method and into the abdominal cavity by the beside assistant surgeon. Initially, the soft end of the glide wire is introduced and over the glide wire the ureteral stent is advanced. By checking the small lines on the ureter, one can easily understand if the ureter is in the correct place. Most of the time 4 small lines that correspond to 20 cm would be enough (Figure 5). Then, both stents are moved through the afferent loop and placed into the ureters up to the renal pelvis. Once the ureteral stents are in the renal pelves, only the excess parts of the ureters are pulled back by the assistant surgeon carefully without removing the whole ureteral catheters; with this maneuver ureters are approximated to the afferent loop (Figure 6).

Using a double armed atraumatic 4/0 monocryl or 4/0 barbed suture (e.g Quill or Stratafix) uretero-ileal
anastomosis is performed. First, the suture is passes through the afferent loop wall in external to internal direction at 6 o’clock position, then through the ureters in internal to external direction (Figure 7). It is important to make sure that the meso of the ileal segment stays at the bottom. By applying a running fashion suturing technique both sides of the anastomosis is completed one by one (Figure 8, 9). As the sutures proceed ureters and afferent loop are approximated to each other. Samples for surgical margins are excised from the distal section of ureters and taken out (Figure 10).
The remaining gap on the afferent loop is closed with a running 3/0 V-Loc suture keeping the ureteral stents in between that will prevent any urine leakage (Figure 11). Eventually the afferent loop is retroperitonealized using a 3/0 or 4/0 vicryl suture (Figure 12).