of the PCNL procedure by doing a systematic
ic sweeping of all the reachable pelvicyceal
system with rigid nephroscope, to remove
all the clots, sand debris, and dust. This vacu-
uming method is the technique of choice for
removing matrix stones. We had begun to
use this technique since 1997, and we had
used it in above 1000 PCNL without noting
any complication related to the technique.
Conclusion: This technique provides
the greatest chances to have a "stone free"
status, from even the fine sand debris. Can
this technique lead to a lower stone recur-
cence rate by reducing the residual stone
burden? Prospective studies are necessary.

VID-31 Percutaneous Renal Displacement
Using the Needle Technique
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Introduction and objective: Due to the
increased risk of intrathoracic complica-
tions, many authors have cautioned against
a percutaneous approach above the 12th rib,
and even discouraged it above the 11th rib.
We present a video of our experience of
percutaneous renal upper pole access using a
percutaneous renal displacement tech-
nique, to render the superior calyx reach-
able below the 11th rib. We describe a renal
displacement technique using an 18-gauge
needle, and its use in different situations.

Material and Methods: We present our
technique of upper pole renal puncture,
using percutaneous needle renal displace-
ment technique, in high-locted kidneys
with various degree of difficulty. The needle
renal displacement technique is performed
under fluoroscopic guidance, with the X-ray
beam perpendicular to the tract. Initially,
a lower or middle calyx is punctured with
an 18-gauge diamond-tipped needle.
Then, a stiff shaft hydrophilic guidewire
is inserted to protect urothelium from
the needle-tip. The needle’s proximal-end
is inserted to protect urothelium from
the needle-tip. The needle’s proximal-end
is inserted to protect urothelium from
the needle-tip. The needle’s proximal-end
is inserted to protect urothelium from
the needle-tip. The needle’s proximal-end
is inserted to protect urothelium from

Results: A caudal renal displacement, of
many millimetres to few centimetres, is
gained. There is also a slight inversion of
the normal axis of the kidney. The renal
upper pole becomes more accessible to
puncture below the 11th rib or even the 12th
rib, so decrease of intrathoracic morbidity.
Sometimes, if one displacement technique
is not sufficient, 2 or even 3 displacements
are performed. The displacement has
always been possible in kidneys with no
surgical history. However, it failed when
the kidney had been fixed by post-surgical
adhesions. This technique has also been
used to immobilize mobile kidneys or to
reorient complex and malrotated kidneys.

Conclusion: Percutaneous needle renal
displacement technique may render the
superior calyx more available while avoid-
ing or decreasing intrathoracic compli-
cations, but are effective only when the
kidney is mobile. This technique can be
used to perform some calyx reorienta-
tion and to fix very mobile kidneys.

VID-32 Laparoscopic Anatrophic
Nephrolithotomy for Complex
Staghorn Calculi with Early
Unclamping and Controlled
Hypotension: An Attempt to
Preserve Renal Function
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Introduction and Objectives: There
are clear indications for the treatment of
complex staghorn stones by Anatrophic
Nephrolithotomy: When a reasonable
number of sittings are unlikely to clear the
calculi, b. other endourologic interven-
tions have failed, c. an associated structural
anomaly needs correction or d. percu-
taneous access is technically unfeasible.
anatrophic nephrolithotomy is the recom-
ended procedure. Laparoscopy offers a
minimally invasive option to these patients.

Materials and Methods: Laparoscopic
anatrophic nephrolithotomy was performed
in 8 patients with complex staghorn calculi.
Mean patient age was 49 years (35-62),
mean stone size was 53 mm (35-70). The principles
of open anatrophic nephrolithotomy are
followed. The hilum is dissected; the artery
and vein isolated and controlled with
bulldog clamps. An incision is made with
a laparoscopic knife in the avascular plane
along Brodel’s line, approximately 1 cm from
the lateral aspect of the kidney. The stone is
extracted. The large vessels that are visual-
ized are oversewn individually. Controlled
Hypotension is applied minutes prior to hi-
lum release: The clamps are removed within
20 minutes. Any additional bleeding vessels
are oversewn. The blood pressure is gradu-
ally restored. As hemostasis is confirmed, the
parenchyma is closed in a running fashion.

Results: All patients were completed lapa-
roscopically. Mean operative time was 142.5
min, mean warm ischemia time was 20.8
min. Average blood loss was 315 cc, mean av-
erage stay was 3.5 days. Complete clearance
of the calculus was obtained in 5 patients.
The 3 months’ post-operative scan showed
an average reduction of 6.6%, which re-
turned to normal in the long-term follow-up.

Conclusions: Our goal, besides removing
the stone, is to preserve renal function. The
technique has evolved achieving excellent
hemostasis with an accurate incision along
Brodel’s line and early unclamping along
with controlled hypotension, to reduce ischemia time. Advantages of this tech-
nique are that it diminishes ischemia time,
ensures hemostasis prior to kidney closure
and decreases the risk for arteriovenous
fistula or aneurysm formation. We hope this
technique leads to preservation of renal
function in patients with staghorn calculi.

VID-33 RPLND in Post-Chemotherapy
Residual Mass with 360 Degree
Involvement of the Aorta:
A Surgical Challenge
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Introduction and Objectives: Post-che-
motherapy retro-peritoneal lymph node dis-
section in patients with non-senomatous
germ cell tumour of the testis is a formi-
dable surgery. A 360 degree encasement of
the aorta by the post-chemotherapy residual
mass adds a major challenge to this proce-
dure. In this video we demonstrate a tech-
nique of handling this complex problem.

Material and Methods: A 23-year-old man
presented with big post-chemotherapy
residual masses in the retro-peritoneum.
His tumour markers had normalised. His
CT abdomen revealed an 18x14x10cm
mass having cystic and solid components.
Superiorly the mass was reaching the su-
perior mesenteric artery (SMA). The left renal
vessels were completely encased. There was
moderate left hydronephrosis. Further down
the aorta was completely surrounded and
lifted by the mass (360 degrees encase-
ment). There were inter-aorto-caval, retro-
caval, para-caval, right and left common
iliac components of the mass. The patient
was explored with left thoraco-abdominal
incision. Supra-coelac aorta was identi-
fied. Dissection was carried along its left
border and then along the anterior surface.
The origin of SMA was identified and kept
safe. The dissection was shifted inferiorly
to identify the left common iliac artery
below the mass. The whole mass was lifted
and slowly separated from the posterior
abdominal wall till the left edge of the aorta.