



Robotic Buccal Ureteroplasty Using HUGO-Ras: A Challenging Case

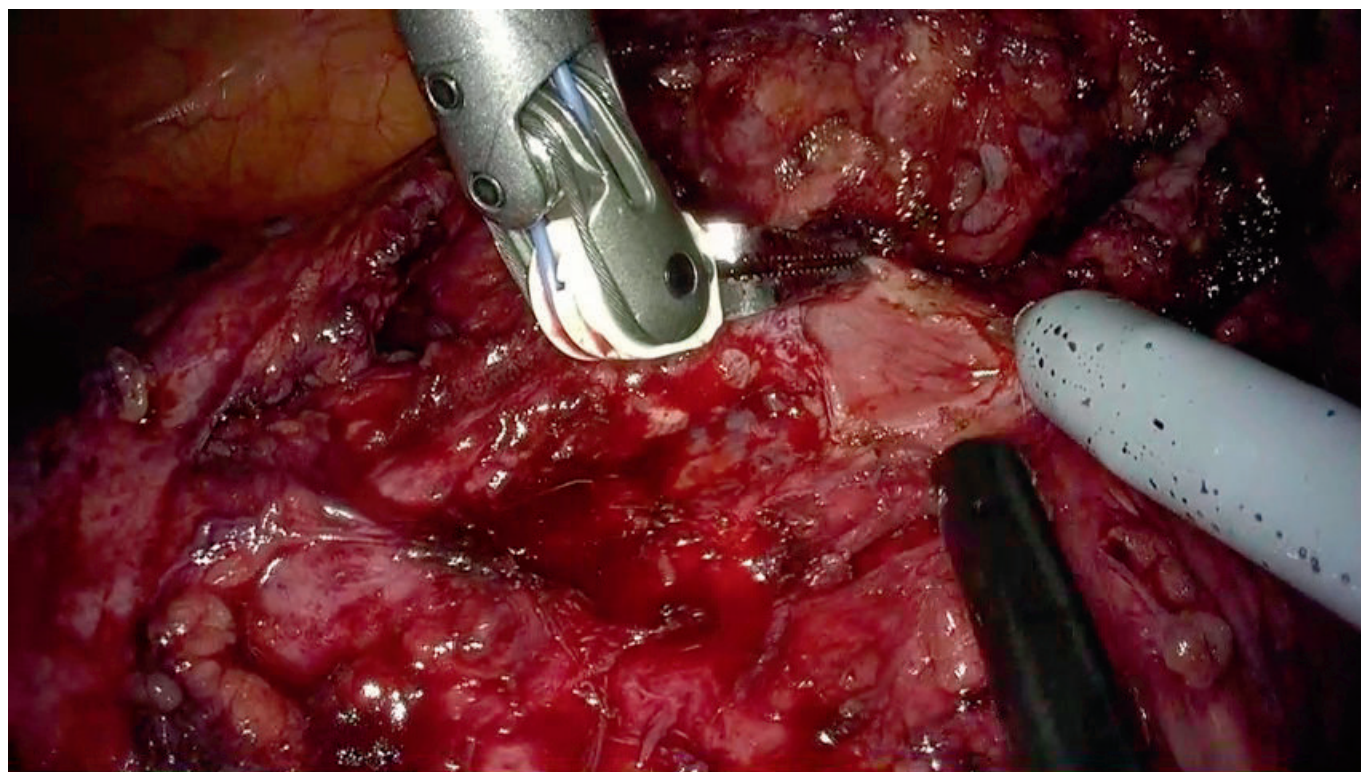
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Ureteral strictures are a very challenging problem for urologists. In the developed countries, the most common causes include lithiasis and iatrogenic. Since the early 2010s¹, robotic buccal ureteroplasty has been used successfully in mostly complex cases by multiple authors.

the first attempt of correction was a ureteral reimplantation with a Boari flap. After removal of the ureteral catheter, there was a re-stenosis, with no possibility of ureteral catheterization. A nephrostomy tube was placed. The patient was referred to our centre at this point and proposed to do a ureteroplasty with buccal mucosa graft.

The patient was positioned in dorsal decubitus with a slight Trendelenburg tilt. Placement of ports in a W configuration. The



Aceda ao vídeo no link: https://drive.google.com/file/d/1CCABN8zBGY5tKRhXfCAuwrWNmO9osBTc/view?usp=drive_link

In this video, the authors present a challenging case of robotic buccal ureteroplasty using the robotic-assisted system HUGO™.

We present a case of a 44-year-old male with an iatrogenic stricture of the ureter. The stricture was made during an anterior rectal resection in 2021, with an iatrogenic lesion of the ureter, and

surgery started with lysis of adhesions to free up the area. Exposure of the area with marked induration corresponding to ureteral stricture and adhesions to the previous Boari flap. Instillation of saline (SF) through the nephrostomy tube (NPC) to confirm ureter position. Identification of marked fibrosis involving the entire pelvic course of the ureter up to the insertion of the neo-ureteral meatus in the Boari flap. Release of the ureter and resection of its anterior plate involving the entire stenotic area (approximately 5 cm) up to near the bladder insertion. Meanwhile, a second surgical team was harvesting the patient's oral mucosa. Then we proceed to the

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introduction of JJ stent under direct vision with a cystoscope and confirmation of its correct positioning. Anastomosis of the oral mucosa graft onlay to the anterior surface of the ureteral defect using 4/0 monocryl sutures. Confirmation of watertightness through instillation of saline through the nephrostomy tube. Mobilization of the peritoneal flap over the intervened area.

Procedure completed without complications. To date, no report of stenosis.

We show that robotic buccal ureteroplasty is a safe and feasible surgery in complex cases of ureteral stricture. The authors aim to expand their experience in this procedure.

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MAR: Conceptualization; Investigation (surgical participation); Data curation (video editing); Writing – original draft.

DGS, PP and MSR: Investigation (surgical participation); Data curation (video correction and editing); Writing – review & editing.

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