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**Minimal invasive technique for the treatment of uretero-ileal anastomotic obstruction**

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**Introduction:** Stenosis and obstruction of the uretero-ileal anastomosis is a common complication of radical cystectomy procedures, encountered in rates between 2-10%¹,². Treatment of anastomotic obstruction is based upon the excision of the anastomotic area performed through an open (invasive) technique³. Herein we are describing the recanalization of a complete anastomotic obstruction based on minimal invasive procedures.

**The case:** A 60 year old male, suffering from diabetes mellitus, arterial hypertension and with a BMI>35, submitted to a radical cystoprostatectomy operation with Bricker urinary diversion due to a T3N0M0 transitional cell carcinoma of the bladder. At 5 months postoperatively, he had the first episode of left pyelonephritis. Despite the adequate treatment, the infection recurred within 5 weeks. Imaging of the urinary tract revealed ipsilateral hydronephrosis which was a new finding. Antegrade urography with simultaneous retrograde loopography revealed a 2 cm long left anastomotic obstruction. Looposcopy using a 15.5 flexible cystoscope was performed but could not reveal the anastomotic orifice. Afterwards, a 0.035 inch guidewire was inserted through a percutaneous nephrostomy to the distal end of the ureter and was guided as close to the tip of the cystoscope as possible. Under fluoroscopic guidance, the guidewire and the ureteroscope were meticulously aligned. Using the stiff end of the guidewire, a puncture was made throughout the obstruction area targeting to the tip of the cystoscope. Once the tip of the guidewire appeared in the lumen of the ileal loop, it was grasped with the cystoscope grasper and curried out of the stoma. A balloon dilatation of the obstructive area with pressure up to 15 Atm for 3 minutes was performed. Finally a self retained urinary stent was left in place. Due to ureteric and ileal peristalsis, 2 months later the stent displaced by its correct position and was not replaced. After a 10-month follow up, the patient remains symptoms free and has a patent uretero-ileal anastomosis.

**Conclusions:** In selected cases with relatively short and easy to access uretero-ileal anastomotic obstructions, minimal invasive procedure may offer adequate treatment to the patient avoiding thus the complication of a permanent nephrostomy and the risks of a major open procedure.

**References:**

