PREOPERATIVE DIAGNOSIS:, Right renal mass.,POSTOP DIAGNOSIS: , Right renal mass.,PROCEDURE PERFORMED:, Laparoscopic right radical nephrectomy.,ESTIMATED BLOOD LOSS:, 100 mL.,X-RAYS: , None.,SPECIMENS: , Right radical nephrectomy specimen.,COMPLICATIONS: , None.,ANESTHESIA: ,General endotracheal.,DRAINS:, 16-French Foley catheter per urethra.,BRIEF HISTORY: , The patient is a 71-year-old woman recently diagnosed with 6.5 cm right upper pole renal mass. This is an enhancing lesion suspicious for renal cell carcinoma versus oncocytoma. I discussed a variety of options with her, and she opted to proceed with a laparoscopic right radical nephrectomy. All questions were answered, and she wished to proceed with surgery as planned.,PROCEDURE IN DETAIL:, After acquisition of appropriate written and informed consent and administration of perioperative antibiotics, the patient was taken to the operating room and placed supine on the operating table. Note that, sequential compression devices were placed on both lower extremities and were activated per induction of anesthesia. After institution of adequate general anesthetic via the endotracheal route, she was placed into the right anterior flank position with the right side elevated in a roll and the right arm across her chest. All pressure points were carefully padded, and she was securely taped to the table to prevent shifting during the procedure. Her abdomen was then prepped and draped in the standard surgical fashion after placing a 16-French Foley catheter per urethra to gravity

drainage. The abdomen was insufflated in the right outer quadrant. Note that, the patient had had previous surgery which complicated accesses somewhat and that she had a previous hysterectomy. The abdomen was insufflated into the right lateral abdomen with Veress needle to 50 mm of pressure without incident. We then placed a 10/12 Visiport trocar approximately 7 cm lateral to the umbilicus. Once this had entered into the peritoneal cavity without incident, the remaining trocars were all placed. Under direct laparoscopic visualization, we placed three additional trocars; an 11-mm screw-type trocar in the umbilicus, a 6-mm screw-type trocar in the upper midline approximately 7 cm above the umbilicus, and 10/12 trocar in the lower midline about 7 cm below the umbilicus within and over the old hysterectomy scar. There were some adhesions of omentum to the underside of that scar, and these were taken down sharply using laparoscopic scissors.,We began nephrectomy procedure by reflecting the right colon, by incising the white line of Toldt. This exposed the retroperitoneum on the right side. The duodenum was identified and reflected medially in a Kocher maneuver using sharp dissection only. We then identified the ureter and gonadal vein in the retroperitoneum. The gonadal vein was left down along the vena cava, and the plane underneath the ureter was elevated and this plane was carried up towards the renal hilum. Sequential packets of tissue were taken using primarily the LigaSure Atlas device. Once we got to the renal hilum, it became apparent that this patient had two sets of renal arteries and veins. We proceeded then and skeletonized

the structures into four individual packets. We then proceeded to perform the upper pole dissection and developing the plane above the kidney and between the kidney and adrenal gland. The adrenal was spared during this procedure. There was no contiguous connection between the renal mass and a right adrenal gland. This plane of dissection was taken down primarily using the LigaSure device. We then sequentially took the four vessels going to the kidney initially taking two renal arteries with the endo GI stapler and then to renal veins again with endo GI stapler sequential flaring. Once this was completed, the kidney was free except for its attachment to the ureter and lateral attachments. The lateral attachments of the kidney were taken down using the LigaSure Atlas device, and then the ureter was doubly clipped and transected. The kidney was then freed within the retroperitoneum. A 50-mm EndoCatch bag was introduced through the lower most trocar site, and the kidney was placed into this bag for subsequent extraction. We extended the lower most trocar site approximately 6 cm to facilitate extraction. The kidney was removed and passed off the table as a specimen for pathology. This was bivalved by pathology, and we reviewed the specimen.