



# Robotic Seminal Vesicle Surgery: The Key Steps

Mezylis Artykov, Hakan Bahadır Haberal, Ahmet Güdelođlu, Mustafa Sertaç Yazıcı, Cenk Yücel Bilen

Hacettepe University Faculty of Medicine, Department of Urology, Ankara, Turkey

## Abstract

Seminal vesicle (SV) cystic masses are rarely encountered entities in daily clinical practice. They are mostly asymptomatic and require no treatment; however, surgical removal of the cyst is highly effective treatment in symptomatic cases. Due to embryological mesonephric duct abnormality, surgical SV cysts most often present as a part of Zinner's syndrome (renal agenesis, ipsilateral SV cyst and ejaculatory duct obstruction). In this video article, we summarise our minimally invasive surgical approach to two consecutive cases of symptomatic SV cyst at our institution.

**Keywords:** Seminal vesicle, seminal vesicle mass, seminal vesicle cyst, robotic surgery, laparoscopy

Before the main procedure, cystoscopy was performed and a six Fr ureteral catheter was placed in the healthy solitary kidney. After placing the Foley catheter, the patient was repositioned.

The patient was placed in a low lithotomy, 30 degree Trendelenburg position. All pressure points were carefully padded to avoid secondary injuries. Capnoperitoneum was created using the Veress needle technique. After introducing an 8-mm robotic camera port, the remaining robotic trocars were introduced into the abdomen under direct vision. All robotic trocars were placed in a straight line. A 12-mm assistance trocar was placed most laterally to the left lateral robotic trocar, while a 5-mm assistance trocar was placed more cranially on the pararectal line. The robotic system was placed at the patient's feet and docked. The procedure was conducted under an average pressure of 13-15 mm Hg. Throughout the procedure, the assistant remained on the left side of the patient, and the assistant's monitor was placed on the right side of the operating table. Maryland bipolar, fenestrated prograsp and monopolar scissors instruments were utilised.

The parietal peritoneum was incised at the level of Denonvilliers fascia and dissection was performed in a sharp and blunt fashion anteriorly to Denonvilliers fascia and posteriorly to SV. Later on, the dissection plane was advanced anteriorly to the SV.

Afterwards, lateral and medial dissections were performed. The left vas deferens was identified and transected as well.

Throughout the dissection, bleeding was controlled either by bipolar or monopolar cautery. Blood supply to the cystic tissue through irregular vessel structures were controlled using Hem-o-lock clips when necessary.

Specimens were retrieved from the abdominal cavity using an endo-catch bag. Afterwards, the incised peritoneum was repaired with Hem-o-lock clips. Trocars were removed and the drain was placed through the previously formed trocar defect on the abdominal wall under direct camera vision. The ureteral catheter was removed immediately after the procedure in the operating room, while the foley catheter and abdominal drain were removed within 12 and 24 hours after the surgery, respectively.

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**Address for Correspondence:** Mezylis Artykov, Hacettepe University Faculty of Medicine, Department of Urology, Ankara, Turkey

**Phone:** +90 552 230 11 74 **E-mail:** dr.m.artikov@gmail.com **ORCID-ID:** orcid.org/0000-0002-8470-8246

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