

Ideas and Innovations

Paper ID	Paper Title	Abstract	Author Names
74	Safety and efficacy of dartos preserving circumcision in patients with diabetes mellitus	<p>Aims and Objectives: To present our novel technique of dartos preserving circumcision and compare its safety and efficacy with the traditional sleeve resection technique for circumcision in patients with phimosis and diabetes mellitus.</p> <p>Methodology: We reviewed our technique of dartos preserving circumcision in 12 diabetic patients and retrospectively compared the outcomes with 12 diabetic patients who had undergone sleeve resection circumcision at our center from January 2015 to April 2016. The outcomes studied were operation time, estimated blood loss, postoperative complications, postoperative pain score, wound healing time and time to return to work. In dartos preserving circumcision, a circumferential incision was made in outer skin at corona level and the skin was dissected free from underlying dartos using sharp and blunt dissection. The prepuce orifice was bluntly dilated and prepuce retracted to make the inner incision. A skin deep incision was made to connect both circumferential incisions in dorsal midline. The prepuce skin was dissected off the dartos circumferentially preserving dartos and frenular artery. Reapproximation was done using interrupted 4/0 Vicryl Rapide™. Sleeve circumcision was done in the standard method and reapproximation was done using interrupted 4/0 Vicryl Rapide™. Results: The dartos preserving circumcision group had less bleeding, lower postoperative pain score, faster wound healing and rapid return to work, when compared to the sleeve circumcision group. The operation time was similar in both groups. The incidence of complications (bleeding and infection) was significantly lower in the dartos preserving circumcision group. Conclusion: Dartos preserving circumcision is a more safe and efficacious technique than sleeve resection in diabetic patients with phimosis</p>	Raguram Ganesamoni*, Advanced Uro Center, Nagercoil, Tamil Nadu, India; PY Henry, Lifeline Superspeciality Hospital; L Jeslin, Advanced Uro Center
95	Innovations Galore-15 (a new technique to repair recurrent urethrocutaneous fistula following hypospadias repair)	<p>Introduction: Avoiding overlapping of suturelines, advancing adjacent skin flap over the site of fistula closure, interposing watertight tissues like dartos or tunica vaginalis are some of the steps taken to avoid recurrence after repair of post hypospadias repair fistula. But scarred skin not allowing a satisfactory mobilization of tissues, impaired vascularity around the fistula and tension of skin closure over the interposed tissue form the causes of failure in such repairs. Materials and methods: At the age of 1, the child with penoscrotal hypospadias underwent Chordee correction on 25.3.2002 and Dennis Browne urethroplasty on 23.12.2002; urethral calibration on 1.2.2003 & 9.5.2003 and fistula repair thrice on 31.12.2003, 26.5.2007 & 21.5.2008. At the age of 15, he was still having a proximal urethral fistula. Under SA, oval shaped incision was made around the fistula. Skin edges were dissected off the fistula. Fistula edges were excised and closed in 2 layers over a 16 F Foley cath placed in urethra. The incision was extended into the scrotum. A triangular patch of skin to match the size of the skin defect was marked on one side of the incision and was dissected with the dartos muscle underneath it intact. The dartos was dissected towards scrotum as a flap adequately to advance it to the skin defect without tension. The skin patch over dartos was sutured to the edges of skin defect at the site of fistula closure. The skin of the extended incision was sutured over the dartos flap. Results : The technique described above achieved the dual goals of interposing a vascularised pedicle flap over the site of fistula closure and achieving a tensionfree skin closure. On followup till now there is no leak and the healing is satisfactory. Literature survey for such a procedure of skin patch over dartos flap to repair fistula following hypospadias repair did not reveal any such reported earlier Conclusion: Necessity is the mother of invention/innovation.</p>	Kannan Krishnasamy*, Dhanalakshmi Srinivasan Medical College
98	Port site hernia repair using Thomson Carter needle	<p>Port site hernia is one of the uncommon complications of laparoscopic procedures. Management of port site hernias too can be attempted laparoscopically. Usually mesh hernioplasty is done for repair of the defect. Small defects can be managed by direct closure of the sheath alone. We present the technique of meshless closure of small port site hernia using Thomson Carter needle and under laparoscopic guidance.</p>	Manickam Ramalingam*, PSG Institute of Medical Sciences; Kallappan Senthil, Urology Clinic; Anandan Murugesan, PSG Institute of Medical Sciences; Mizar G Pai, Urology Clinic
119	MicroBox White light PCNL trainer	<p>Aim:To create simplest PCNL puncture trainer & learn principles of puncture. Design: 2 transparent plastic boxes reformed to upper deck made of lids 3 cms apart & lower deck with bottoms glued 3cms apart with side slit. Keyboard flash LED light is moved over slit in lower deck with change in position varying 0-30d craniocaudal as well as mediolateral. Lids are hollowed like window frame. White paper & transparent polythene sheet is tautly fixed by closing upper & lower lids which are adhered. PCS is made of clear straw & ampoule ends sealed with cellotape. The light from below the straw in alignment is 0d as light moves out the angulation increase to 30d & similarly when light is moved caudally (towards bladder). White paper capture shadow images. Triangulation principle is used for Puncture by spinal needle. Observations: Calyx orientation is identified by rotation 0- 30 d. On 0 -30d mediolateral rotation :When needle is fairly below calyx the gap between needle tip & calyx tip widens apart & needle shortens moving laterally immediately (within few degrees). When needle is fairly above (superficial) the calyx the gap between the needle tip & calyx tip shortens immediately & needle overshoots calyx (appears to move towards pelvis when needle appears inside calyx but actually superficial & viceversa) relatively. The changes are remarkable when needle is farther from the calyx. When calyx is punctured properly both 0 & 30 d images are congruent with needle inside. On caudal 30d rotation (towards bladder), needle turns cephalad wrt calyx longaxis when it is deeper to calyx & caudal if superficial (same direction of light). Needle indents calyx and displaces PCS medially. Results: PCS filled with Ultravist & sealed to obtain images under c arm. Image analysis with same fixed reference points in ROI in both systems showed 97.3% SD 0.7 (n=20) matching after adjusting magnification. Conclusion: This inexpensive, simple, portable model with reasonable haptics can be used for dry lab training for PCNL puncture.</p>	Shankar Ram*, TD MCH vandanam

120	White light C arm for PCNL simulation	<p>Aim: To design C arm for PCNL puncture simulation using White light .Methods /Design :Parts:Cyclehemirim,2 inchPVC Coupler with T-collar,PVC pipes,LED lightwith diverging beam & adjustable focus, BP apparatus stand ,8 MP Logitech web cam ,Plastic trolley with mounted inverted Plastic box 20x20 cms with fenestrated lid (4cms ht),a side window & open below.A cylindrical plastic container with both ends open.Camera is mounted in upper end of rim facing down & centered to plastic drum projecting down to center.Lower end of drum is covered with white paper which captures the images by LED light placed on the other end of rim. In between lies PCS (made of transparent straw & ampoules that can be filled with contrast)hinged in plastic trolley.A layer of polythene sheet (cortex)is trapped by the lid lying above the PCS stabilise the needle in position during puncture.Glues are used to fix components.C-arm rotation is Hand driven through custom made PVC coupler junction. Degrees are gauged .Images are seen in the monitor display as black & white of shadow.The axis of centre of the light and the paper drum is always maintained in all rotations(craniocaudal and lateral medial)avoiding parallax.Puncture with IP needle through sponge in side window. Triangulation technique and Bulls eye technique is used. RESULTS:The simulator system images are equivalent with c arm images .The device is simple cost effective ,light weight with reasonable tactile feed back allows Satisfactory interpretation of shadows of calyx and its relationship with that of needle in two different angles . Independent operability with real time advancement and puncture is simulated .Appearance & maneuvering is similar to C-ARM. CONCLUSION: We hypothesise these simulators aid in structured training and improve Learning curve of PCNL & eventually reduce fluoroscopy time during procedure.</p>	<p>Shankar Ram*, TD MCH vandanam ; Aby Madan, TD MCH ; Nazar M , TDMCH</p>
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