

Paper ID	Paper Title	Abstract	Video	Author Names
13	Cystoscopy guided laparoscopic diverticulectomy	60 year old male patient presented with obstructive voiding symptoms. History of TURP done 2 years back. Ultrasound was suggestive of Bladder Diverticular on the Right posterolateral aspect. CECT confirmed the same, Cystoscopy showed large single diverticular 2cm, lateral and posterior to the right ureteric orifice. In view of obstructive voiding symptoms Laparoscopic diverticulectomy was planned. During surgery cystoscope with light is kept at the diverticular neck which guided the entire laparoscopic dissection. Only one transfixation stitch at neck of diverticular done. Detrusor buttoning done over the same.		Chandra Mohan Vaddi*, Preeti Urology & kidney Hospital; Ramakrishna Paidakula, Preeti urology & kidney Hospital
16	Laparoscopic nipple valve ureteric reimplantation	Aims and Objectives: To evaluate the feasibility of Laparoscopic nipple valve reimplantation for obstructed megaureter. Methodology: 35 yr old patient presented with complaints of vague right loin pain for the past 1 year. On evaluation, he was found to have right obstructed megaureter with secondary calculi. Under general anesthesia, using 4 ports, 3 x 10mm and 1 x 5 mm, laparoscopy was done. Right ureter was dissected from pelvic brim to bladder. Ureter ligated at the level of narrowing and cut. Secondary calculi were removed. Bladder was prepared for reimplantation - cystotomy at the dome. The end of the dilated ureter was reflected on to itself to form a everted nipple. The nipple is maintained using interrupted 4-0 vicryl sutures. The reconstructed ureteric end was reimplanted using interrupted 3-0 vicryl sutures. The 'nipple' acts as a valve preventing reflux. Results: The operative time was 150 min and blood loss was around 50ml. patient was started orally on POD1 and drain removed on POD5. Urethral catheter removed on POD14. Patient is asymptomatic now at 6 months follow up. Conclusion: Laparoscopic nipple valve ureteric reimplantation is an effective and feasible method for reimplantation in dilated ureters, where long tunnels may be required, providing minimally invasive benefits.		Kallappan Senthil*, Urology Clinic; Manickam Ramalingam, PSG Institute of Medical Sciences; Anandan Murugesan, PSG Institute of Medical Sciences; Mizar G Pai, Urology Clinic
17	Laparoscopic Madigan prostatectomy	Introduction Open prostatectomy remains the technique of choice in patients with large benign prostate glands. Madigan prostatectomy is the technique of open prostatectomy where the urethral mucosa is preserved. We present the video of laparoscopic Madigan prostatectomy. Methods: The patient is under general anesthesia and placed in a steep Trendelenburg position. A 2–4 cm midline incision just above pubis is made. Retzius space is developed by balloon distension. Five extraperitoneal trocars in an inverted U shape is placed. Periprostatic fat is cleared by blunt dissection and prostate capsule visualised. Transverse incision is made over the capsule after controlling the dorsal venous complex. The plane of cleavage is defined between the adenoma and the capsule with careful blunt and sharp dissection using a harmonic scalpel and suction cannula. Medial aspect of the adenoma is visualised and dissected away from the urethral mucosa. Any inadvertently opened mucosa is closed with 3-0 vicryl and capsular vessels controlled with 2-0 vicryl sutures. Capsulotomy is closed with 2-0 vicryl. Drain is placed. Results: The operative duration was 130 minutes and blood loss was around 100ml. Patient was started orally on POD0 and irrigation stopped on POD1. Urethral catheter removed on POD14 and patient		Manickam Ramalingam*, PSG Institute of Medical Sciences; Anandan Murugesan, PSG Institute of Medical Sciences; Kallappan Senthil, Urology Clinic; Mizar G Pai, Urology Clinic
24	LAPAROSCOPIC ANATROPHIC NEPHROLITHOMY FOR RECURRENT STAG HORN CALCULUS	Aim: To demonstrate the feasibility of the procedure for complex calculus disease in a post PCNL kidney Methodology: Cystoscopy done and 5/24 DJ stent placed after doing RGP. Transperitoneal laparoscopic approach with 4 ports was employed. Two 10mm and two 5mm port were used. The primary port was placed on the lateral border of the rectus abdomens one inch above the umbilicus with a Hassan technique. Two accessory ports of 5mm were placed in the left hypochondriac and the iliac fossa in the midclavicular line. The colon was reflected in the white line and reflected medially. the retroperitoneal space was entered and the gerona fascia incised. The ureter was identified and the dissection was carried cephalic and medial to the ureter. Dense adhesions were found in the lower pole and around the renal artery and were dissected with sharp dissection. The artery and vein were dissected separately. A 100 port was placed in the left posterior axillary line midway between the the 12 th rib and the iliac crest. The kidney was dissected all around so as to place a dam to prevent cooling of the adjacent organs. The dam was created with urobag. Cold saline and slush placed on the kidney and the kidney cooled for 20 min after clamping the artery and the vein. Kidney incised 1cm posterior to the lateral edge. the collecting		Mallikarjuna Reddy*, Global Hospital

40	Robotic radical nephrectomy with Level II inferior venecaval thrombectomy with use of robotic bull dog clamps	Aim : To demonstrate the feasibility of robotic radical nephrectomy with Level II inferior venecaval thrombectomy with use of robotic bull dog clamps Material and methods: 52 year old man with hematuria on evaluation found to have large renal mass with a thrombus in the renal vein extending to inferior venecava (IVC). Patient was placed in right lateral position. Da Vinci Si system with 4 arms was used. Adhesions under the liver was released, colon and duodenum was reflected. Initial dissection was started in the interaortocaval region, the lumbar veins encountered were clipped and divided to adequately mobilise the IVC. The renal arteries were identified one by one and ligated with WECK Clips. The IVC was mobilised superiorly upto the edge of the liver. The left renal vein was dissected all around, vascular loops were applied in the infrahepatic IVC , left renal vein and infra renal IVC. Robotic bulldogs were applied after synching the venecava with the help of vascular loops. This at allows easier and stable application of the bull dogs. The IVC was then opened and thrombus was extracted. There was a small area of infiltration of the thrombus to the wall of IVC which was excised. The cavotomy was sutured using 6.0 goretex suture. Then all the clamps were released sequentially. The specimen was	Vishnu R, ASTER MEDCITY COCHIN; Kishore TA*, ASTER MEDCITY COCHIN; Ramaprasad MK, ASTER MEDCITY COCHIN
41	Robotic Renal transplant recipient operation with complete extraperitonealisation of the graft	Aim: To elucidate the method of complete extraperitonealisation of the graft while performing transperitoneal robotic renal transplant recipient operation. Materials:. The Ports are placed in a similar fashion to Robotic Radical Prostatectomy with cephalad displacement of the ports by 4 cm. The procedure starts with incision of peritoneum lateral to contralateral lateral umbilical ligament the incision is extended to the iliac fossa were the graft is placed. This enables to drop down a flap of peritoneum along with bladder. Subsequently iliac vessels are dissected and prepared for anastomosis.. A Pfannenstiel incision is made and a Gel point is inserted through it. The graft is wrapped in ice and a gauze jacket is placed through this incision. Arterial and venous anastomosis are performed using 6.0 Goretex and the graft is flipped to iliac fossa. Vesicoureteric anastomosis was performed by using 4.0 PDS. The peritoneum is reattached to anterior abdominal wall and a drain is placed. After the release of pneumoperitoneum the position of the graft is verified by inserting the camera through the gel point. Results: Our technique of complete extraperitonealisation of the graft replicates closely the technique of open extraperitoneal transplant. The vascular and ureteric anastomosis is completely extra peritonealised. In the	Kishore TA*, ASTER MEDCITY COCHIN; Ramaprasad MK, ASTER MEDCITY COCHIN; Vishnu R, ASTER MEDCITY COCHIN
47	FLEXIBLE URETERORENOSCOPY IN CHALLENGING SCENARIOS	Aims and Objectives: Urolithiasis is a common urological problem with significant morbidity to the patients. The prevalence of urolithiasis in patients with urinary diversions varies from 3 to 43%. The surgical management of ureteric stones in patients after urinary diversion and large impacted calculi is very challenging. We present a video demonstration of management of multiple large calculi in difficult scenarios Methods: Case1: 55 yr Old patient underwent Radical Cystectomy and Ileal Neobladder creation (abroad) 10 years back. CT scan revealed 5 large stones blocking the right ureter joining the neobladder and narrowing at the B/I neoureteric anastomotic site to the neobladder. Multiple unsuccessful open and keyhole attempts were done abroad. At our centre an initial cystoscopy was done, guidewire placed in the neobladder. flexible ureteroscopy was done retrograde, left ureteric orifice to the neobladder identified. Guide wire placed and DJS placed retrograde. Right repuncture through middle calyx done. Flexible ureteroscopy done antegrade , 2 stones pulled in to the lower calyx and fragmented. The stone in the right ureter fragmented completely with Laser. The Neoureteric orifice negotiated and DJS placed antigrade. Case 2: 50 yr old female with large right impacted lower calyx calculi	Datson George*, Lakeshore; George P Abraham, Lakeshore Hospital; Vijay Radhakrishnan, Lakeshore Hospital
48	: LAPAROSCOPIC MANAGEMENT OF POST TRANSPLANT LYMPHOCELE IN DIFFERENT SCENARIOS	Aims & Objectives: Postoperative lymphoceles after renal transplantation appear in up to 18% of patients. It Can cause problems of pressure over ureter, renal vessels, external iliac vein or urinary bladder. Therapeutic options are drainage, needle aspiration with sclerosant injection, or internal surgical drainage by conventional or laparoscopic approach. We present a video demonstration of 3D laparoscopic marsupialisation of post transplant lymphocele in 2 different scenarios. Methods: Case1: 34 yr male, post transplant 6months back .Imaging revealed a 12 X 7 cm posterior collection. Patient in supine position. 3 lateral ports were used. Large peritoneal bulge seen posterior to the graft kidney . Marsupialisation with omental interposition was done. Case2: 18 yr male, post transplant 4months back. Imaging with USG and MRI revealed a large collection along postero-inferior aspect of the transplant kidney inferiorly extending into pelvis and intending right lateral wall of bladder. A laparoscopic ultrasound probe was used to detect the collection and prevent injury to the arterial anastomotic site which was inadvertently exposed during difficult dissection. Results: The operative and post operative details were recorded . A total of 15 patients were treated by the laparoscopic approach. The mean	Datson George*, Lakeshore; George P Abraham, Lakeshore Hospital; Vijay Radhakrishnan, Lakeshore Hospital
50	3 D LAPAROSCOPIC MANAGEMENT OF LARGE RENAL CALCULI	Aims and Objectives : The management of large complex renal calculi and complete clearance remains technically challenging. SWL, PCNL or a combination therapy has limited efficacy. In this video presentation we show our technique of transperitoneal approach for management for large complex renal calculi. We present challenging cases of laparoscopic Anatomic nephrolithotomy for large Staghorn calculi, lap pyelolithotomy for large calculi in normal and pelvic kidneys Methods: Case 1: 64yrs male presented with right flank pain 6 months duration. CT Urogram showed right staghorn calculus measuring 5.3X4.5cm . Patient was taken for right LANL. Right DJS placed. Patient in left lateral position, standard ports inserted, colon reflected, kidney mobilized completely after opening gerota fascia, renal hilum dissected and clamp applied enbloc using laparoscopic satinsky. Nephrotomy incision given along the brodels line, PCS opened along the line of incision and all the calculus removed. The parenchymal defect closed with continuous 1-0 vicryl using hemlock clips, stone clearance confirmed with post op X-Ray, DJ stent removed after 6 wks. Case 2: 72 yr old male with large left pelvic calculi. Lap pyelolithotomy done. Case 3: 32 yr male with left pelvic kidney calculi, difficult lap	George P Abraham*, Lakeshore Hospital; Datson George, Lakeshore; Vijay Radhakrishnan, Lakeshore Hospital

51	3D LAPAROSCOPIC MANAGEMENT OF NODAL RECURRENCE IN RCC - CASE SERIES	Aims and Objectives: Nodal recurrence is rare after radical nephrectomy for clinically localized renal-cell carcinoma (RCC). It is more common in advanced stages like renal vein or IVC thrombus. Aggressive open surgical resection of isolated nodal recurrence can offer durable local control and potential improvement in cancer-specific and overall survival. We present a video presentation of 3D laparoscopic resection of nodal recurrence after radical nephrectomy for clinically localized RCC. Methods: Case 1: 40 yr old lady presented with nodal recurrence in right paracaval region. This patient had initial IVC thrombus(level 1) which was treated laparoscopically. Multiple Lymph nodes were Resected in the paracaval region. The IVC was partially clamped with Lap satinsky and Lymph node infiltration with IVC wall was resected and IVC sutured laparoscopically. Case 2: 69 yr old male was found to have recurrent nodal mass in the left para aortic region. 3D laparoscopic resection of the recurrent mass was done. The dissection was difficult and the mass was very adherent to surrounding structures. Results: 3 patients underwent laparoscopic resection of ipsilateral nodal recurrence. The mean age of patients was 57 years (44–66 y). All had primary tumors with clear-cell histology. 2 of the 3 patients had IVC thrombus. The mean	George P Abraham*, Lakeshore Hospital; Datson George, Lakeshore; Vijay Radhakrishnan, Lakeshore Hospital
62	Primary complete repair of bladder exstrophy and epispadias	Introduction : Bladder exstrophy is a rare condition and primary repair is challenging. An osteotomy is essential for achieving closure when repair is performed after 72 hours of life. We herewith report a case and a video of its management. Case scenario : 2-month old baby, presented with bladder exstrophy and constant leakage of urine. On examination, bladder mucosa was clearly visible with areas of epithelialization; both ureteric orifices were clearly seen with naked eye. Baby also has epispadias and bilateral undescended testis. X-Ray of pelvis revealed pubic diastasis. The baby was thriving well and was taken up for surgery. Primary repair of bladder and epispadias was performed with bilateral anterior pubic ramus osteotomy (video). Gallows traction was applied for postoperative immobilization and the baby tolerated the procedure well. After 3 weeks the healing was excellent with no fistula/ wound dehiscence and the patient is planned for follow up for bladder neck repair and orchidopexy later. Conclusion : Bladder exstrophy management is challenging and involves multiple steps. The options available for osteotomy include: anterior pubic ramus, innominate and posterior iliac osteotomies. The case is being presented for its rarity and to demonstrate the operative steps.	shivraj barath kumar*, srmc , porur; Ramesh babu srinivasan, SRMC , porur; venkat ramanan, SRMC , Porur
66	LAPAROSCOPIC MANAGEMENT OF LOWER MOIETY PUJO IN A CHILD	Introduction: To report laparoscopic management of lower moiety PUJO in a duplex kidney. Objective: Video presentation on laparoscopic pyelo-ureterostomy for lower moiety PUJO Methods: A 10-yr old girl presented with left loin pain of 6 months' duration. Ultrasound revealed hydronephrosis and DTPA showed good function/ drainage. In view of persistent symptoms CT urogram was performed, which picked up a PUJO of lower moiety in a duplex left kidney. Results: Laparoscopic dismembered pyeloplasty was performed anterior to lower polar vessels. RGP and cystoscopy and stenting prior to procedure, helped in anatomical orientation prior to procedure. Conclusion: Laparoscopic lower to upper pyelo-ureterostomy is also an alternative for lower moiety PUJO and in our case standard pyeloplasty was performed as the duplication was complete with normal pelvis and ureter from upper moiety.	SIBI CHAKRAVARTHI*, SRI RAMACHANDRA UNIVERSITY; Ramesh babu srinivasan, SRMC , porur; venkat ramanan, SRMC , Porur
101	Laparoscopic nondismembered pyeloplasty in adults – NH experience	(a) Introduction and Objectives: Pyeloplasty remains the gold standard therapy in the treatment of ureteropelvic junction obstruction. Laparoscopic pyeloplasty provides a minimally invasive alternative to open pyeloplasty without compromise of treatment success or durability. Ever since its introduction by Anderson & Hynes dismembered pyeloplasty is preferred worldwide due to its universal application and excellent success rates. Non dismembered techniques of pyeloplasty are considered useful only in specific conditions. Increased vascularity of the anastomotic segment due to incomplete resection is very helpful for better outcome (b) Methods: The study was conducted in our center from 2011 to 2015. Total of 82 patients underwent lap pyeloplasty during this period and out of this 39 had non dismembered pyeloplasty. The decision to choose the type of pyeloplasty was taken on the bases of presence of crossing vessels on pre-operative imaging studies and intra-operative findings. Data was collected and analyzed and patients were followed up (c) Results: Median age of our patients at time of surgery was about 25 yrs. The majority of patients were male and left sided disease was more common. There were no complications in early post-operative period. There was only one case of	Prashanth Kulkarni*, Narayana Health
110	Retroperitoneal vs Transperitoneal Ureterocalicostomy (for BANGALORE UROLOGICAL SOCIETY VIDEO PRIZE)	a) Introduction and Objective While the method to reconstruct the PUJ or an upper ureteric stricture involves, some form of excision of the ureter and re-anastomosis; the approach to the structures can be changed based on the anatomy of the patient. This video demonstrates the transperitoneal and the retroperitoneal ureterocalicostomy technique and the advantages of each of the retroperitoneal technique. b) Methods The transperitoneal technique demonstrated is a four port approach to perform a ureterocalicostomy in a patient with a PUJ obstruction. While the retroperitoneal approach is a three port standard technique demonstrating the same surgery for a lower moiety PUJ obstruction. c) Results In both the patients the outcome was satisfactory with reduction in the hydronephrosis post surgery and they continue to remain asymptomatic after stent removal. d) Conclusions The retroperitoneal technique provides a quick and direct access to the ureter and the kidney. In reconstructive surgery, especially involving the ureter this reduces the time spent in mobilizing the colon and later in having the colon repeatedly falling into the operative area. The ureter and the lower pole of the kidney require very minimal dissection in the retroperitoneal technique and lie in an ergonomic position that	Krishna Prasad Thyagaraj*, NU Hospitals, Bangalore; maneesh sinha, nu trust hospitals bangalore; Pramod K, NU Hospitals; Pradeepa m g, NU hospitals; venkatesh krishnamoorthy, nu trust hospitals bangalore

118	LAPAROSCOPIC REPAIR OF A SIMPLE VVF IN A COMPLEX PATIENT	<p>Introduction: Approach to Vesicovaginal fistula (VVF) is dictated by surgeon's preference ,location and complexity of fistula.Laparoscopic VVF repair adheres to the principles of transabdominal VVF repair ,while decreasing morbidity and improving cosmesis. Here is presented a typical supratrigonal VVF post Abdominal hysterectomy ,but complex due to previous failed repair and three abdominal surgeries in the past.</p> <p>Materials and methods: 53 yr old post menopausal ,morbidly obese female with BMI 41,presented with continous urinary leak post abdominal hysterectomy 10 years back, was diagnosed to have VVF by cystoscopy.she had underwent failed attempt for repair of the same, adhesionolysis for intestinal obstruction and meshplasty for incisional hernia ,9 yrs,5 yrs and 4 yrs back respectively.Three suprumbilical ports placed for adhesionolysis and 5 more ports placed for Laparoscopic VVF reapiir by standard O'Conor method. vagina and bladder sutured seperately with barbed sutures with lateral peritoneal flap interposed between them due to non-availability of omentum. Results : Operative time was 5 hours with blood loss of 30 ml.length of hospital stay was 5 days. catheter was removed on day10.No leak noted postop ,and recovery was fast with minimal requirement of</p>	Alagappan Chockalingam*, Apollo hospitals
123	ROBOT ASSISTED TOTAL INTRA CORPOREAL ILEAL CONDUIT : MARIONETTE TECHNIQUE	<p>Aim To present the technique of robot assisted intracorporeal ileal conduit construction.</p> <p>Case history A 63 year old lady with muscle invasive bladder cancer underwent robot assisted radical cystectomy, extended pelvic lymphnode dissection and total intracorporeal ileal conduit construction using marionette technique. Total operative time was 510 minutes. Radical cystectomy with extended pelvic lymphnode dissection took 210 minutes and ileal conduit construction required 300 minutes. Total blood loss was 300 ml. Post operative period was uneventful and total hospital stay was six days. Conclusion It is possible to perform total intracorporeal ileal conduit using robot assisted laparoscopic technique without much difference in the cost and operative time.</p>	Vishnu Raveendran*, ASTER MEDCITY; Ramaprasad MK, ASTER MEDCITY COCHIN; Deepak Varma, ASTER MEDCITY; Kishore TA, ASTER MEDCITY COCHIN
127	OUR EXPERIENCE OF TRANSPERITONEAL LAPAROSCOPIC RADICAL NEPHRECTOMY WITH LYMPHADENECTOMY FOR RENAL CELL CARCINOMA – ONCOLOGIC OUTCOME AND OPERATIVE SAFETY Sharma Rakesh M (Uro-oncologist), T Subramanyeshwar Rao (HOD Surgical Oncology) Department of Surgical Oncology, Basavatarakam Indo-American Cancer Hospital & Research Institute, Hyderabad, TS	<p>Abstract INTRODUCTION AND OBJECTIVE: To evaluate the safety of Transperitoneal laparoscopic radical nephrectomy (TrLRN) for large renal cell carcinoma, addressing the issue of risk factors for complications and open conversion, and to assess the oncologic outcome METHODS: Patient with a 7 cm mid pole Right sided Renal mass underwent Transperitoneal laparoscopic radical nephrectomy (TrLRN) with a standard technique. A right iliac fossa incision was performed for the specimen delivery. RESULTS: Tumor size 7 cm, operative time was 180 minutes, and blood loss was 150 ml . No post-operative blood transfusion required. Patient discharged on 4th post-operative day. Post-operative serum creatinine was 1.0 mg/dl. CONCLUSION: Transperitoneal LRN for large RCC is a safe operation. Stage pT3 is a risk factor for open</p>	Rakesh Sharma*, Basavatarakam Indo-American Cancer Hospital; T Subramanyeshwar Rao, Basavatarakam Indo-American Cancer Hospital, hyderabad
129	TRANSPERITONEAL LAPAROSCOPIC RADICAL NEPHRO- URETERECTOMY WITH EXCISION OF BLADDER CUFF WITH LYMPHADENECTOMY FOR UPPER TRACT TCC Sharma Rakesh M (Uro-oncologist), T Subramanyeshwar Rao (HOD Surgical Oncology) Department of Surgical Oncology, Basavatarakam Indo-American Cancer Hospital & Research Institute, Hyderabad, TS	<p>Abstract INTRODUCTION AND OBJECTIVE: Transperitoneal laparoscopic radical nephroureterectomy(TrLRNU) for Upper Tract TCC (UTTCC) with Excision of Bladder cuff, addressing the issue of risk of complications and open conversion, and to assess the oncologic outcome METHODS: Patient with a Right sided mid ureteric tumor underwent Right Ureteroscopy and biosy with DJ stenting. Biospy was High grade Urothelial carcinoma. CECT (Abdomen & pelvis) revealed Right mid ureteric tumor extending to lower ureter. A Cystoscopic Ureteric resection was performed followed by Transperitoneal laparoscopic radical nephroureterectomy(TrLRNU) with a standard technique and intracorporeal bladder suturing was performed. A right iliac fossa incision was performed for the specimen delivery. RESULTS: Total specimen size including the kidney ureter and bladder cuff was approx 30 cm, operative time was 280 minutes, and blood loss was 250 ml. No post-operative blood transfusion required. Patient discharged on 6th post-operative day after drain removal. Per- urethral catheter was removed at 2 weeks. Post-operative serum creatinine was 0.9 mg/dl. CONCLUSION: Transperitoneal LRNU for UTTCC is a safe operation with minimal morbidity and equivalent oncologic outcome.</p>	Rakesh Sharma*, Basavatarakam Indo-American Cancer Hospital; T Subramanyeshwar Rao, Basavatarakam Indo-American Cancer Hospital, Hyderabad

140	ROBOTIC PARTIAL NEPHRECTOMY IN T1B TUMOUR	<p>INTRODUCTION Partial nephrectomy is considered the standard of care for small renal masses. More recently, the role of partial nephrectomy has been expanded to include select patients with T1b renal masses. Retrospective studies have demonstrated the oncologic efficacy of partial nephrectomy in appropriately selected patients with T1b renal tumors achieving the “trifecta outcome” of no perioperative complications, ischemia time of <25 minutes, and negative margins. AIMS AND OBJECTIVES The aim of this video is to demonstrate that the “trifecta outcome” of no perioperative complications, ischemia time of <25 min, and negative margins can be achieved in appropriately selected patients with T1b renal tumors. MATERIALS AND METHODS The patient presented to the outpatient department of urology at our hospital with an incidentally detected right renal mass with no other comorbidities. C.E.C.T KUB demonstrated an enhancing tumor in upper pole of the right kidney measuring 8x6x6 cm. R.E.N.A.L nephrometry score was calculated to be 7a(R-3,E-1,N-2,L-1). Preoperative evaluation was done. His renal function tests were normal. His preoperative haemoglobin was 14. His pre anaesthetic evaluation was done and he was fit to undergo surgery. Informed consent was taken and patient underwent</p>	<p>mir ali*, manipal hospital bangalore; Brendan Dias, Manipal Hospital; Deepak Dubey, Manipal Hospital</p>
159	Laparoscopic Anderson-Hynes Pyeloplasty in an Ectopic Pelvic Kidney	<p>Introduction: Many patients with ectopic kidneys remain often undiagnosed or asymptomatic throughout life. Congenital anomalies of urinary tract are often the underlying causes of pathologies. Ectopic pelvic kidneys often present with PUJ obstruction. We report a case of unilateral ectopic pelvic right kidney associated with right undescended testis. Case Report: A 29 year old male patient presented with lower abdomen pain for 1 month. Genital examination revealed right undescended testis. CT KUB showed ectopic malrotated right kidney with moderate hydronephrosis. DTPA Renogram showed hydronephrotic ectopic right kidney with moderately impaired function due to outflow obstruction. Laparoscopic Right Anderson-Hynes Pyeloplasty with right orchietomy was done. Laparoscopic pyeloplasty is a safe and feasible option in renal ectopia that offers excellent patient outcomes with low morbidity.</p>	<p>Lalith Sagar*, Narayana Medical College; Surya Prakash Vaddi, Narayana Medical College, Nellore; Sreedhar D, Narayana Medical College, Nellore; venu manne, narayana medical college and hospital, nellore; Vijay Bhaskar G, Narayana Medical College, Nellore</p>