Introduction: When ileal conduit construction is performed for urinary tract drainage during radical cystectomy, the conduit is usually constructed in the right lower abdomen. However, no reports have described ileal conduit construction in the left lower abdomen when it cannot be performed on the right. In addition, some ingenuity is necessary for construction on the left.

Case presentation: A 75-year-old woman visited our hospital with chief complaint of gross hematuria. Computed tomography and cystoscopy showed a huge bladder tumor, and blood analysis showed anemia. The patient was treated by radical cystectomy with ileal conduit construction. An ileal conduit was constructed in the left lower abdomen; it was impossible to construct in the right lower abdomen because of the abdominal wall scar hernia due to the past open surgery.

Conclusion: We herein reported a patient who underwent ileal conduit for urinary diversion on the left side of low abdominal wall.

Key words: cystectomy, ileal conduit, left abdomen, left side, reverse side.

Keynote message

We reported a patient who underwent radical cystectomy followed by ileal conduit on the left side of low abdominal wall. In this case, no perioperative complications, including ileus, were observed after surgery. We herein reported a patient who underwent ileal conduit on the left lower abdomen and described the surgical technique.
of the conduit and the stoma was constructed on the anal side so that the intestinal peristalsis was in the same direction as urine flow. The ureteral conduit anastomosis was performed using the Wallace method\(^3\) (Fig. 2b). Using the peritoneal incision outside the descending colon, the ileal conduit was retroperitoneally formed to cover the ureteral conduit anastomosis. An ileal stoma was then created outside the body through the rectus abdominis muscle.

**Discussion**

An ileal conduit is generally constructed in the lower right abdomen. Anatomically, the right side is considered to be the side on which the anal side can properly open to the lower abdomen along the direction of the physiological ileal peristalsis. This may be because the ileal conduit anastomosis readily approaches the ileum regardless of whether the Bricker or Wallace method is used.\(^4\) Furthermore, it is easy to imagine retroperitonealization of the ileal conduit.

In contrast, when constructing the conduit on the left side, not only the free ileum preparation site is located far from the ileocecum, but the tube–conduit anastomosis is displaced further toward the head to allow for opening on the anal side to the left lower abdomen along with the peristaltic movement of the ileum. Attention should also be paid to avoid twisting the mesentery of the free ileum (Fig. 3). The peritoneal incision must be extended outside the descending colon to the cranial side to retroperitonealize the ileal conduit, which is displaced more cranially than when construction is performed on the right (Fig. 4). Although not physiological, when the oral side of the ileum is opened to the left lower abdomen, the ureteral anastomosis can be performed at the same height as the right; thus, the operation itself is simple and easy to imagine. Since the urine flow opposes the peristaltic movement of the ileum, there is concern about the conduit ureteral reflux when the ureteral anastomosis is performed using the Wallace method. Even if the Bricker method is used, there is no concern about urinary stagnation in the conduit. However, no reports have described the conduit opening the oral side to the lower abdomen without following the physiological intestinal peristalsis, whether this might be a problem remains unknown. No postoperative bowel complications developed in this case.

**Conclusion**

We reported a patient who underwent radical cystectomy followed by ileal conduit on the left side of low abdominal wall.
We keep in mind to create ileal conduit on the left side of abdominal wall, if ileal conduit cannot be created on the right side.

**Ethics statement**

This case report was approved by the Institutional Review Board of Chiba University Hospital (No. 2564), and written informed consent was obtained from the patient.

**Acknowledgment**

We thank Angela Morben, DVM, ELS, from Edanz Group (www.edanzediting.com/ac), for editing a draft of this manuscript.

**Conflict of interest**

The authors declare no conflict of interest.

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