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PI-01 RECTOURETHRAL FISTULAS SECONDARY TO PROSTATE CANCER TREATMENT: MANAGEMENT AND OUTCOMES

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CONCLUSIONS: Robotic repair of intraprostatic RUF with robotic prostatectomy and urethrovesical reanastomosis is feasible and represents an attractive alternative to the standard approaches, even in a complex post-radiation setting. This technique requires advanced robotic experience.

Source of Funding: None

V4-13 POSTERIOR APPROACH TO ROBOTIC SIMPLE PROSTATECTOMY

Brian Cronson, Andrew Harbin, Laura Giusto, Anuj Desai, Ziho Lee, Joshua Kaplan, Blake Moore, Daniel Eun, Philadelphia, PA*

INTRODUCTION AND OBJECTIVES: This video describes our novel technique for performing robotic simple prostatectomy (RSP) for benign prostatic hyperplasia (BPH). This approach also allows for performance of concomitant procedures such as bladder diverticulectomy, cystolithotomy, or ureteral reimplantation.

METHODS: From May 2013 through September 2014, a single surgeon (DE) performed RSP on 21 patients with symptomatic BPH using our posterior approach technique. Novel aspects of this technique include a posterior cystotomy and anastomotic exclusion of the prostatic fossa. The posterior cystotomy offers easy visualization of the enlarged gland without mobilization of the bladder. Closure of the prostatic fossa is achieved by anastomosing the urethra to the bladder neck in an extraperitoneal fashion, after adenoma removal, obviating the need for post-operative bladder irrigation. Concomitant procedures performed included bladder diverticulectomy (3), cystolithotomy, and ureteral reimplantation.

RESULTS: The mean patient age was 68 years (60-85) and mean prostatic volume was 128.5 cc via transrectal ultrasound (55-200). Mean pre-operative IPSS score and SHIM score were 19.9 (7-28) and 11.9 (1-24) respectively. Average console time was 168.5 min (71-307) and average EBL was 276.2 mL (range 50-1000). The mean weight of removed adenoma was 84.5 grams (34-153). The average length of stay was 1.1 days (range 1-3). There were no intraoperative urologic complications and pathology confirmed BPH in all cases except 1 patient with incidental pT1a disease. Post-operative complications consisted of 1 initial failed voiding trial. Post-operatively, IPSS scores were significantly improved (Mean 4.2, range 0-12, $p < 0.001$). There was no significant difference in the post-op SHIM score (Mean 11.7, $p=0.94$). Mean follow-up was 3 months.

CONCLUSIONS: We present our experience with this novel approach to RSP. Patients who underwent RSP had significant improvement in post-operative lower urinary tract symptoms without compromise in erectile function. The benefits of this approach include extraperitoneal anastomosis, elimination of post-operative bladder irrigation and shorter hospital stay.

Source of Funding: None

V4-14 ROBOT ASSISTED MILLIN PROSTATECTOMY

Giuseppe Simone, Rocco Papalia, Mariaconsiglia Ferrero, Riccardo Mastroianni, Salvatore Guaglianone, Michele Gallucci, Rome, Italy*

INTRODUCTION AND OBJECTIVES: Robot assisted Millin prostatectomy has demonstrated to be an effective treatment for large benign prostate hyperplasia (BPH). This video highlights surgical steps of this procedure.

METHODS: With the patient in steep Trendelenburg position a 5 trocar access was performed. The prostate-bladder junction was identified; the ventral aspect of prostatic lobes was progressively dissected up to identify the apex and the urethra. The urethra was transected and the bladder catheter secured with an hem-o-lock. With a

traction applied to the catheter the lateral and the posterior aspects of the lobes were isolated. The bladder neck was then transected and the posterior aspect of the lobes completely cleaved. Hemostasis of the prostatic fossa was obtained with monopolar coagulation and trigonization performed with a 2/0 monocryl running suture. Finally, the lateral and the ventral aspects of the bladder neck were approximated with the ventral and lateral aspects of the bladder neck, respectively.

RESULTS: Operative time was 75 minutes. Intraoperative estimated blood was 200 mL. The patient was discharged on first postoperative day and the urethral catheter was removed on 3rd postoperative day. Prostate weight was 85 grams.

CONCLUSIONS: Robot assisted Millin prostatectomy is a feasible technique that may be successfully applied to large BPH as alternative to endoscopic treatments.

Source of Funding: None

Plenary Session I - Best Abstracts

Sunday, May 17, 2015

7:30 AM-12:00 PM

PI-01 RECTOURETHRAL FISTULAS SECONDARY TO PROSTATE CANCER TREATMENT: MANAGEMENT AND OUTCOMES

Catherine Harris, Benjamin Breyer, San Francisco, CA; Ramon Virasoro, Virginia Beach, VA; Alex Vanni, Burlington, MA; Daniela Andrich, London, United Kingdom; Gerald Jordan, Virginia Beach, VA; Leonard Zinman, Burlington, MA; Anthony Mundy, London, United Kingdom; Jack McAninch, San Francisco, CA*

INTRODUCTION AND OBJECTIVES: Rectourethral fistula is a known complication of prostate cancer treatment. Reports in the literature on technique and outcomes of RUF repair are limited to case reports and single surgeon case series. We aim to examine variations in techniques and outcomes of RUF repair in a multi-institutional setting.

METHODS: We retrospectively identified patients who underwent rectourethral fistula repair after prostate cancer treatment from four reconstructive centers of excellence (University College London Hospitals; University of California, San Francisco; Lahey Clinic; Devine-Jordan Center for Reconstructive Surgery and Pelvic Health) over a 15-year period. We examined the type(s) of prostate cancer treatment, method of fistula repair, outcomes, and need for subsequent procedures.

RESULTS: 201 patients underwent rectourethral fistula repair following prostate cancer treatment with an overall success rate of 91.5% (184). 97 (48.2%) fistulas occurred after radical prostatectomy alone, and 104 (51.8%) had some form of radiation/ablative treatment. Of the radiation/ablative patients, 85 patients (42.3%) had radiation/ablation treatment only, and 19 (9.5%) had both surgery and radiation/ablation. 155 (73%) patients had a bowel diversion prior to or at the time of fistula repair, and this was similar in both surgical and radiation/ablation fistula groups. More patients with radiation/ablation fistulas had placement of an interposition flap or graft at the time of fistula repair (91% vs 53%). 40 (19%) patients had a concomitant bladder neck contracture or urethral stricture identified and repaired at the time of fistula repair. 12 (5.6%) patients underwent salvage fistula repair. 3 (1.4%) ultimately underwent a permanent urinary diversion. 24 (11%) patients required placement of an artificial urinary sphincter.

CONCLUSIONS: Rectourethral fistulas occurring from prostate cancer therapy can be reconstructed successfully in a high percentage of patients, avoiding permanent urinary diversion in these complex cases.

Source of Funding: None