Radical cystectomy has been the gold standard for treatment of muscle invasive bladder cancer. However, this kind of therapy may have an impact on quality of life, including sexual-, urinary and social function. For this reason we performed prostate sparing surgery during radical cystectomy for invasive bladder cancer without compromising oncological outcome.

Material & Methods: Between December 2003 and December 2005 34 patients with a mean age of 63.2 years (± 8.0 years, ranged 48-79 years) underwent radical cystectomy with prostate sparing surgery due to bladder cancer. Preoperative evaluation included a normal digital rectal examination, PSA lower than 4 ng/ml and an inconspicuous transrectal ultrasound. All patients underwent prostate biopsy preoperatively to exclude prostate cancer. Involvement of the prostatic urethra was excluded by means of preoperative endoscopic biopsies. Surgery consisted of radical cystectomy, hemiprostatectomy and resection of the prostate adenoma in the lower part of prostate as well as regional lymphadenectomy. Seminal vesicles and the peripheral zone of the prostate were maintained. All patient underwent biofeedback-treatment pre- and postoperatively. The follow-up was 11-34 months.

Results: Postoperative pathological stage was pT2 in 2 patients, pT3 in 1 case, pT1 in 5 cases, pT2 in 20 cases, pT3 in 6 cases and N+ in 4 cases. We found no prostate cancer on histopathological evaluation. Except of 7 patients no patient had a deterioration of sexual function. 30/34 patients were fully continent (no pad) during daytime and nighttime, as long as they void 1 or 2 times a night to stay dry. The mean operation time was 225 minutes (± 42 minutes, ranged 167-379 minutes). Mean operative blood loss was 473 ml (± 255 ml, ranged 100-1000ml).

Conclusions: Radical cystectomy with prostate sparing surgery in patients with invasive bladder cancer allowed to preserve the external urethral sphincter and the neuromuscular bundles at the posterolateral edge of the prostate. Additionally, with hemiprostatectomy we are able to create a wide neovesico-urethral anastomosis to prevent strictures, urinary retention and mucous retention. It is absolutely necessary that this procedure is restricted to highly selected patients, especially without concomitant prostate cancer.

Is Retropereitoneoscopic Peripelvic Cyst Ablation a Simple Issue?

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Introduction & Objectives: Laparoscopic decortication is recommended as a first line treatment in symptomatic peripelvic cyst, when aspiration and instillation of sclerosant is contraindicated or unsuccessful. Sclerosing forms may be treated by percutaneous aspiration, but the treatment of these cysts has changed considerably over recent years due to ability of laparoscopic approach to treat cysts even in proximity with renal vessels. Retroperitoneoscopic approach appears to be the most appropriate and most effective solution. We describe and define the operative technique, findings and results of retroperitoneoscopic ablation of peripelvic renal cyst.

Material & Methods: Between January 2002 and Sept 2006, 23 patients with symptomatic peripelvic renal cysts type I and II after Bosniak classification, mean size 7.09±1.86 centimeters, underwent retroperitoneoscopic cyst ablation. Complex renal cysts were excluded. The Wong-Baker pain scale was used to assess the pre and postoperative pain score. The success was defined as no recurrence at the most recent ultrasound or CT scan. Preoperative work-up included clinical exam, lab exam, intravenous pyelogram, ultrasound and CT scan. The essential features of three different cases with retroperitoneoscopic decortications are presented. Dissection was uniformly complex because of the depth to which the cyst extended into the renal parenchyma and the overlying renal vessels and collecting system. Mean follow-up was 27±14.9 months.

Results: The mean operative time was 55.6±14.1 min. Symptomatic success was achieved in 91.3% of patients and imaging proved success was achieved in 95.6%. The mean hospital stay was 3±0.8 days.

Conclusions: Laparoscopic ablation of peripelvic cysts is a challenging yet feasible procedure. Because of the cyst’s intimate location in the hilum, a retroperitoneal approach may be preferable to clearly identify the collecting system and renal pedicle.