The authors conclude that the balance between a greater proportion of men having high Gleason disease and a greater proportion with small, less advanced tumours may explain the stability in survival.

Dr. Athanase Billis
Full-Professor of Pathology
State University of Campinas, Unicamp
Campinas, São Paulo, Brazil
E-mail: athanase@fcm.unicamp.br

RECONSTRUCTIVE UROLOGY

Low yield of early postoperative imaging after anastomotic urethroplasty
Terlecki RP, Steele MC, Valadez C, Morey AF
Department of Urology, Wake Forest University School of Medicine, Winston-Salem, North Carolina, USA
Urology. 2011; 78: 450-3

Objectives: To evaluate the necessity and clinical effect of posturethroplasty imaging.
Methods: We reviewed our database of all urethroplasties performed by a single surgeon at our referral center during a 2-year period. The patients underwent voiding cystourethrography at a mean of 24 days postoperatively. The data analyzed included patient history and demographics, operative details, imaging results, and clinical outcomes.
Results: From 2007 to 2009, 210 patients underwent urethral reconstruction at our center. The patients undergoing meatoplasty or staged repairs were excluded, leaving 156 patients with postoperative imaging studies for analysis. Of 110 anterior urethroplasties, 59 (54%) consisted of excision and primary anastomosis, 28 (25%) an augmented anastomotic procedure, and 23 (21%) a pure ventral onlay with a flap or graft. All 46 posterior urethroplasties were performed with scar excision and primary anastomosis. Of the 156 patients, only 4 (3%) had extravasation on postoperative voiding cystourethrography (2 after posterior urethroplasty, 1 after augmented anastomosis, and 1 after ventral onlay)--all were successfully managed with catheter replacement and removal at a mean of 8 days afterward. None of the 59 men undergoing excision and primary anastomosis demonstrated extravasation.
Conclusions: Extravasation on posturethroplasty voiding cystourethrography is rare after approximately 3 weeks of catheter drainage. Imaging can be omitted after uncomplicated excision and primary anastomosis urethroplasty.

Editorial Comment

Urethral imaging after urethroplasty is performed in order to rule out extravasation. If extravasation is seen then the catheter is replaced in order to divert the urine until the extravasation is healed. Such imaging is commonly done as either a peri-catheter retrograde urethrogram or a voiding cystourethrogram after catheter removal. The authors demonstrate that when removing the catheter at a mean of 3.5 weeks after surgery, the incidence of extravasation is extremely low. Furthermore, in anastomotic urethroplasties there were no instances of extravasation. The suture line is shorter in anastomotic urethroplasties so it is intuitive that these would have a lower risk of prolonged extravasation.

Others have pushed for early catheter removal but have admitted a higher chance of urinary extravasation.

I think what is clear from this article is that surgeons have a choice - they can leave the catheter in for a long period of time and not perform imaging or they can try to remove the catheter early but should perform imaging if they do so. With prolonged catheterization comes increased risk of urinary tract infection and patient discomfort. With early catheter removal comes the risk that about 1 in 5 will need the catheter replaced for another week or two due to extravasation on imaging. It would seem that for patients who live close to a reconstructive center, early catheter removal with imaging and a chance of catheter replacement may be preferable. For those who live far from their reconstructive surgeon or who want to minimize extra visits, a longer period of catheterization without subsequent imaging would be appropriate.

Dr. Sean P. Elliott
Department of Urology Surgery
University of Minnesota
Minneapolis, Minnesota, USA
E-mail: selliott@umn.edu

Long-term results of permanent urethral stent Memotherm implantation in the management of recurrent bulbar urethral stenosis

Sertcelik MN, Bozkurt IH, Yalcinkaya F, Zengin K
Ankara Diskapi Yildirim Beyazit Training and Research Hospital 1. Urology Clinic, Ankara, and Department of Urology, Karaman State Hospital, Karaman, Turkey
BJU Int. 2011; 108: 1839-42. doi: 10.1111/j.1464-410X.2011.10230.x.

Study Type - Therapy (case series) Level of Evidence4 What's known on the subject? and What does the study add? Milroy reported 84% success at a mean of 4.5 years follow-up by usage of a permanently implantable "urolume" spent in 1993. Study Type - Therapy (case series) Level of Evidence Memotherm was developed later, especially for urologic use. Our study is one of the largest in this urea, with a high number of patients and a long follow-up period.

Objective: To evaluate the effectiveness and long-term results of permanent urethral stent (Memotherm) implantation in the treatment of recurrent bulbar urethral stricture.

Patients and Methods: In all, 47 patients with a history of previous unsuccessful treatment for bulbar urethral stricture were treated using Memotherm bulbar urethral stents between 1998 and 2002. Long-term follow-up data was analysed and discussed.

Results: At the end of the 7-year period 37 of 47 patients (78.7%) had been treated successfully. Post-micturition dribbling incontinence lasting up to 3 months after stent placement occurred in 32 (68.1%) patients, but this was reduced to only seven patients (14.9%) by the 7-year follow-up. There was stress incontinence of various severities in nine (19.2%) patients at the 1-year follow-up. These patients were those who had stenosed urethral segments adjacent to the external sphincter. At the long-term follow-up < 10% of the patients had stress incontinence complaints.

Conclusion: Memotherm is a good treatment option in patients with recurrent bulbar urethral stricture of any cause.