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URETHROPLASTY BY SCROTAL FLAP FOR LONG URETHRAL STRICTURES

By J. P. BLANDY, D.M., M.Ch., F.R.C.S., M. SINGH, F.R.C.S. and G. C. TRESIDDER, F.R.C.S.

From the Department of Urology, The London Hospital

THE great majority of urethral strictures are best managed by regular and gentle dilatation. With time and patience it is usual for the dilatations to become progressively less painful and the intervals progressively longer, and for strictures which respond to this management there is of course no question of urethroplasty.

A minority of strictures fail to respond to these traditional measures, however skilfully applied. Sometimes there are complications such as fistulæ, or false passages: in some the dilatations are excessively difficult or painful and in others dilatation is followed by bacteræmia: here urethroplasty is a solution to the problem.

Simple excision and end-to-end anastomosis of the urethra is useful when the stricture is short and situated in the anterior urethra. Where there is a longer stricture of the anterior urethra, it can be corrected by methods which make use of the buried skin-strip principle of Denis Browne (Swinney, 1952, 1954, 1957). In the posterior urethra, if the stricture is short, the pull-through operation of Badenoch (1950) gives excellent results, with the important advantage that it is completed in one stage.

Unfortunately there remain a large number of strictures which fall into none of these categories. For example, Swinney's operation cannot be used when the stricture extends round the curve of the bulb towards the membranous urethra, because the taut skin of the perineum cannot be brought up to the edges of this part of the urethra without tension. Again, pull-through operations apply only when the gap can be overcome by mobilisation of the healthy urethra distal to the stricture. In practice it may be difficult to determine just how far a stricture extends proximally, particularly when the distal part of the stricture is so tight that only a small amount of contrast medium can be injected past it: here a technique is needed which is so flexible that it can be adapted to the operative findings.

Going some way to meet these requirements are methods described by Bengt-Johansen (1953), Turner-Warwick (1960) and Gil-Vernet (1966), which make use of an inlay graft of scrotal skin. None of these operations is technically easy, principally because it is always difficult to place the sutures accurately high up in the prostatic urethra. A further stricture will develop if the edge of the skin is not accurately apposed to the urethra, or if it is sutured under tension.

When stricture occurs after these procedures, it can be corrected by a simple Y-V advancement. This makes use of an inverted U-shaped flap, which is essentially derived from scrotal skin. Experience with this revision operation led us to believe that a urethroplasty making use of this kind of flap could be used as a primary procedure. In the event we found not only that the operative technique was rendered much easier, but the end-results fully justified the change of approach.

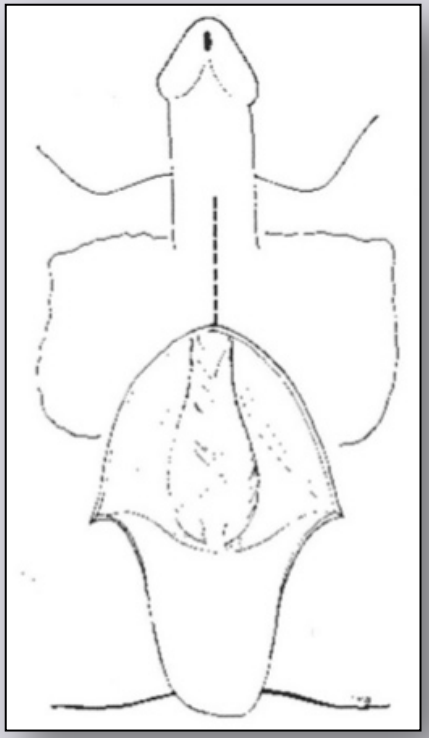
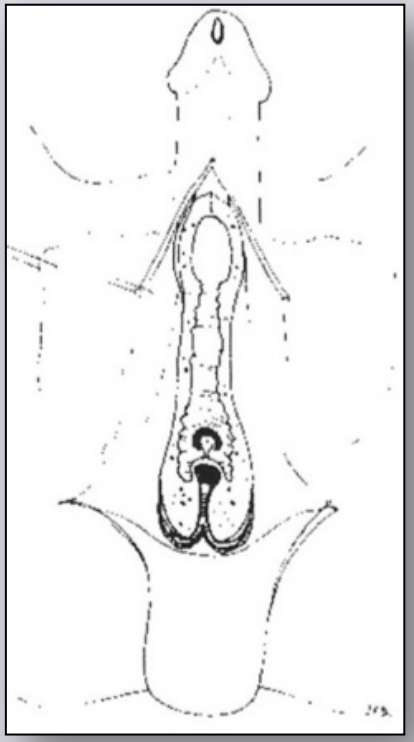
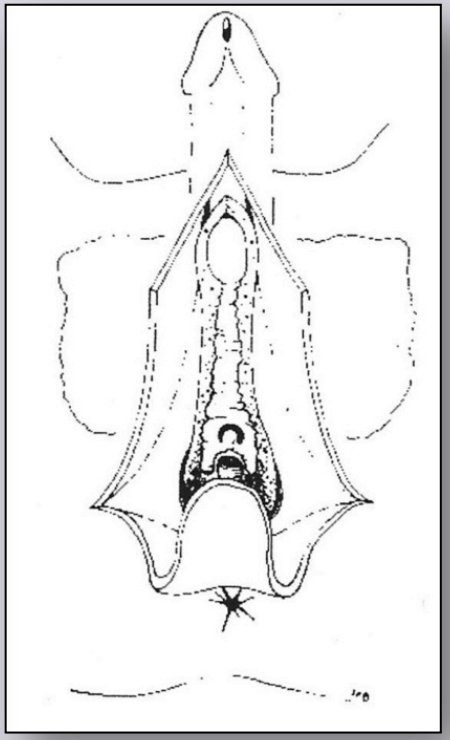
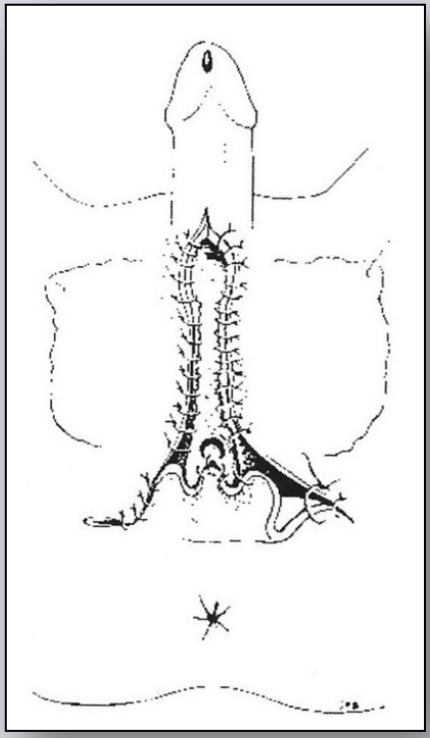
The design of the flap is such that it cannot be placed under tension and the most difficult step of the operation—namely placing the sutures high in the prostatic urethra—is carried out before the skin inlay is put into position, at the stage when access to the prostatic urethra is best.

Fundamentally this technique is a much exaggerated version of the method originated by Leadbetter (1960) and developed by Wells (1966), but there is one rather important difference.

Br J Urol 1968, 40: 261-267

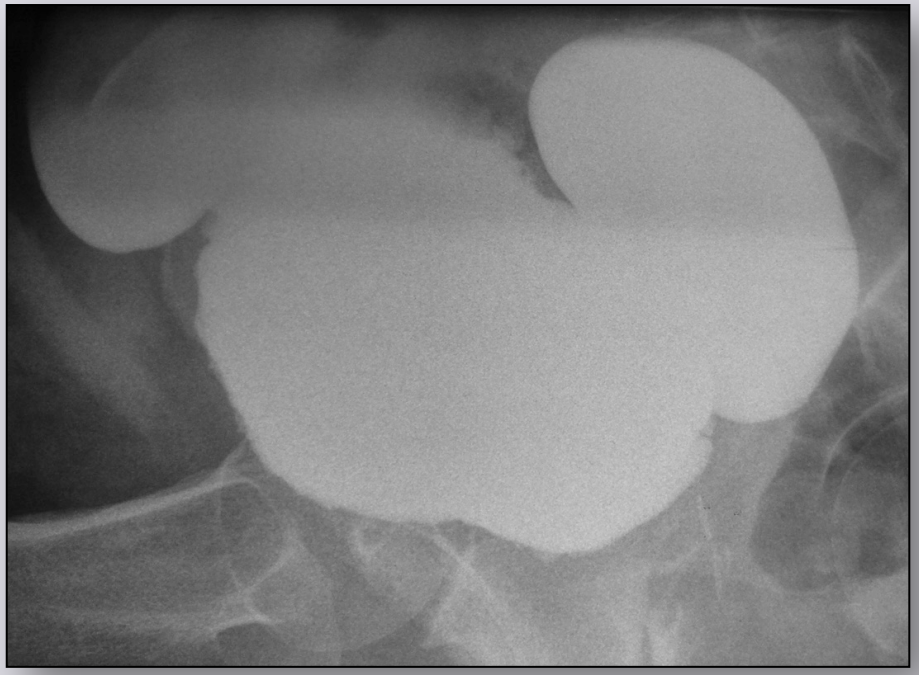
J. Peter Blandy

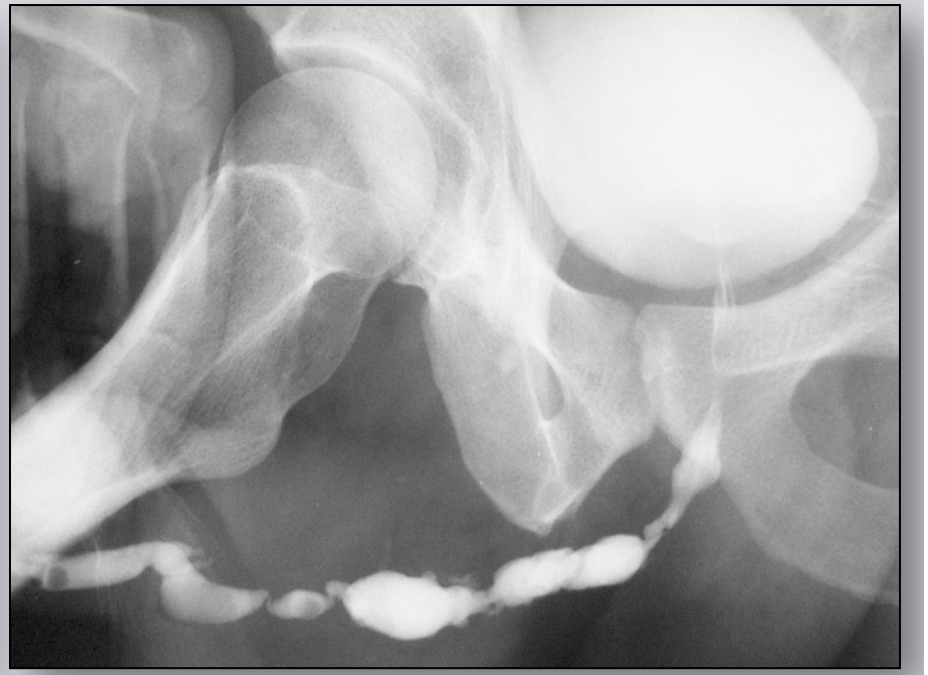
Definitive perineal urethrostomy

Br J Urol, 1968: 40; 261-267

When?



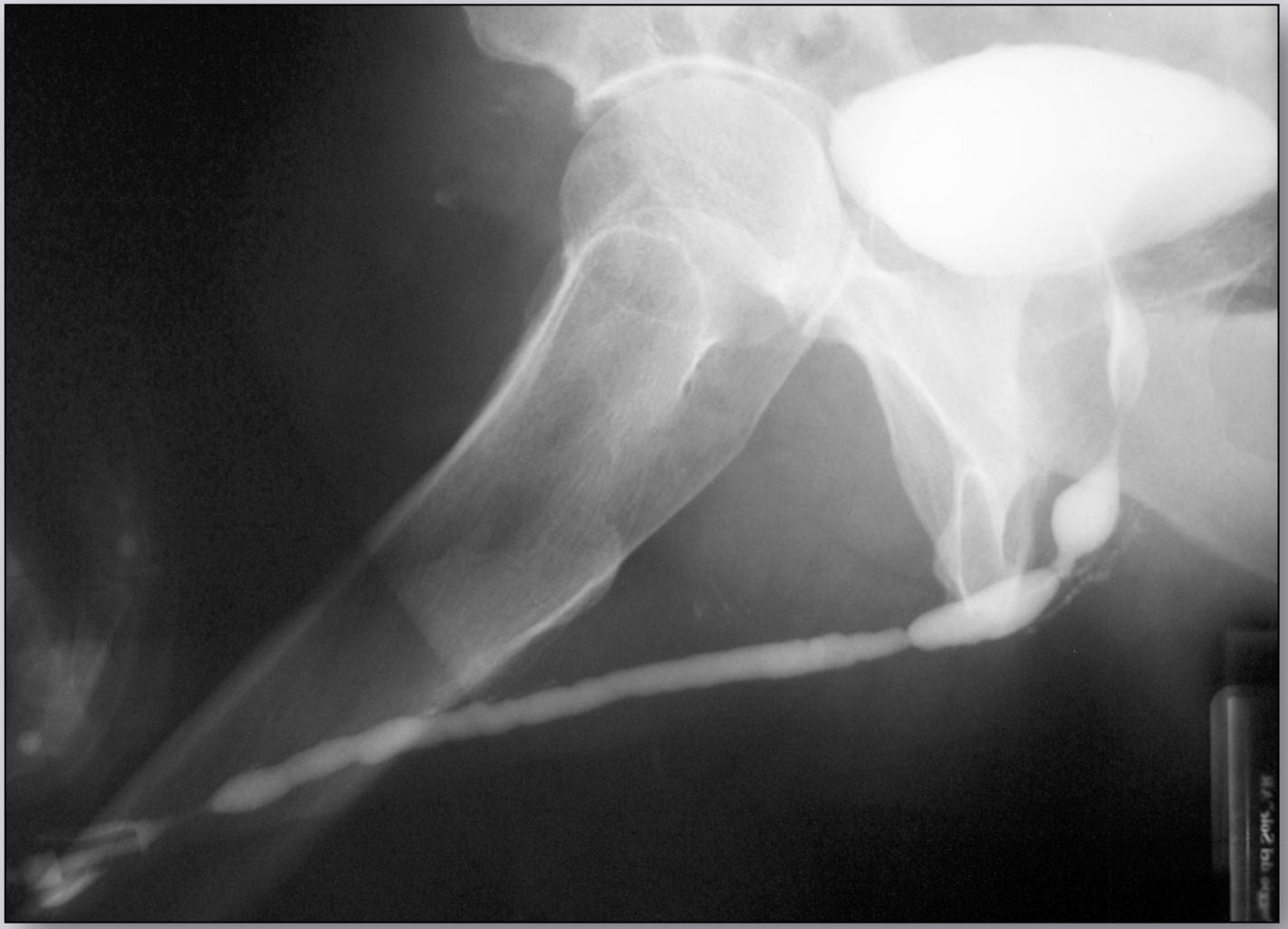


Patient clinical history:

- Numerous prior failed surgeries
- Aggressive genital lichen sclerosus
- Failed hypospadias repair
- Age and life expectancy
- Co-morbidity and anesthesia risk
- Quality of life
- Patient expectation

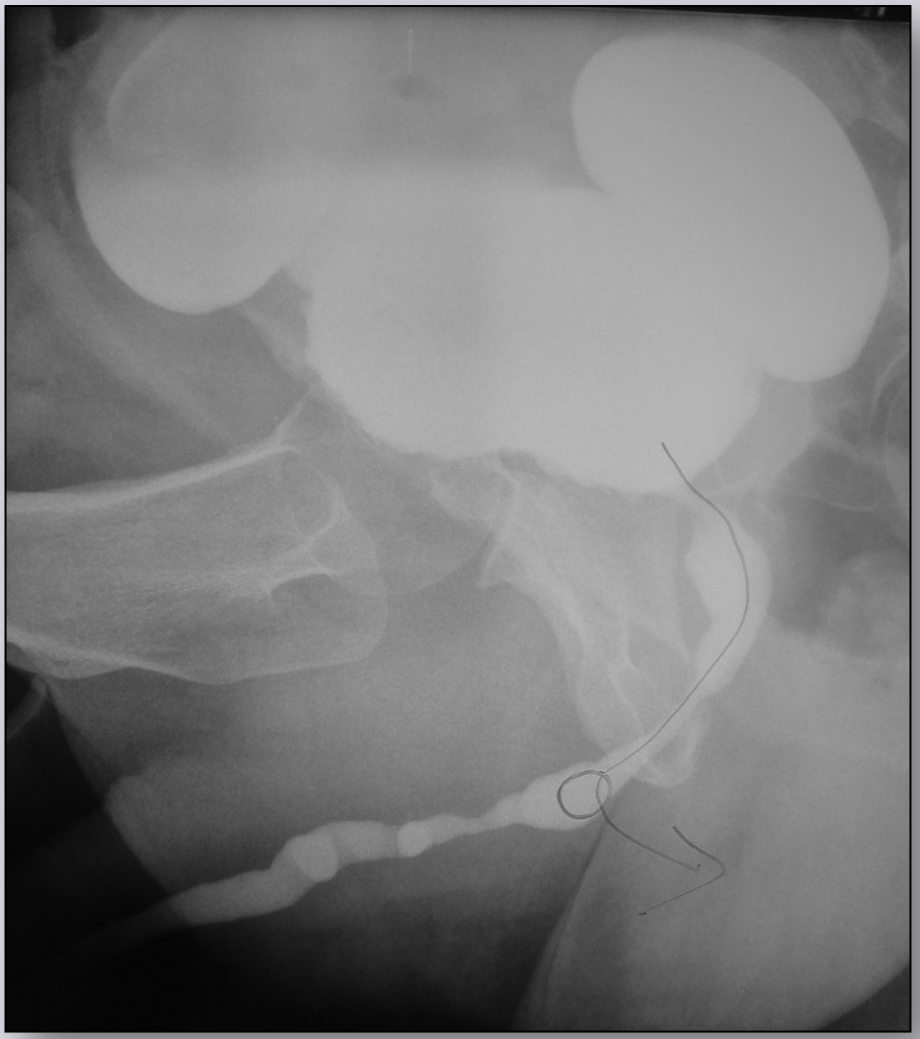

MEDICO
I am tired !!!!!!

Pre-operative investigations



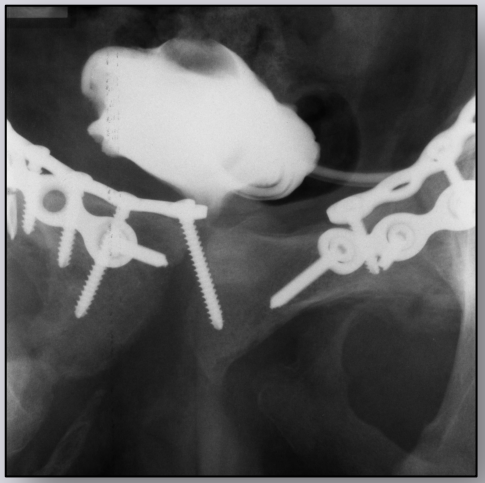
Retrograde urethrography

Pre-operative investigations



Voiding cysto-urethrography

Cystography – supine position



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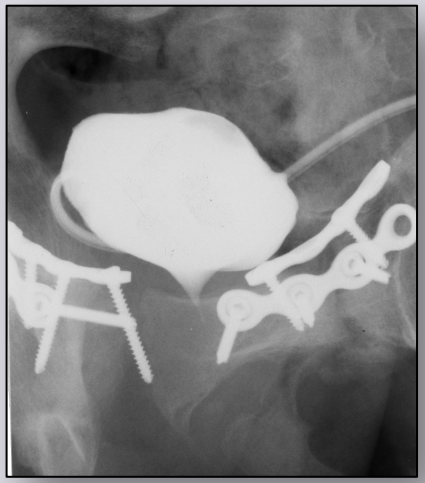

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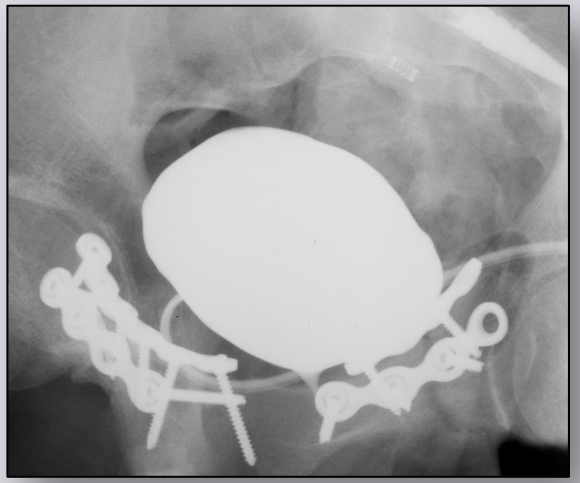

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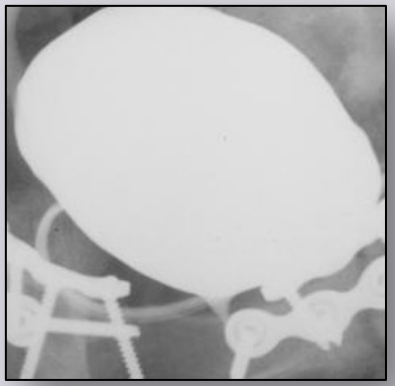
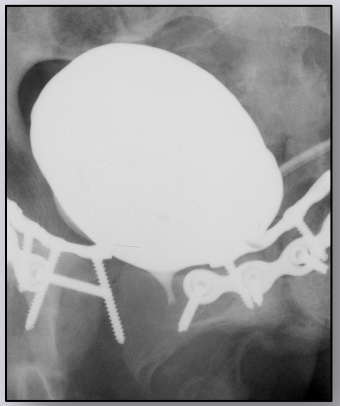
Cystography – standing position





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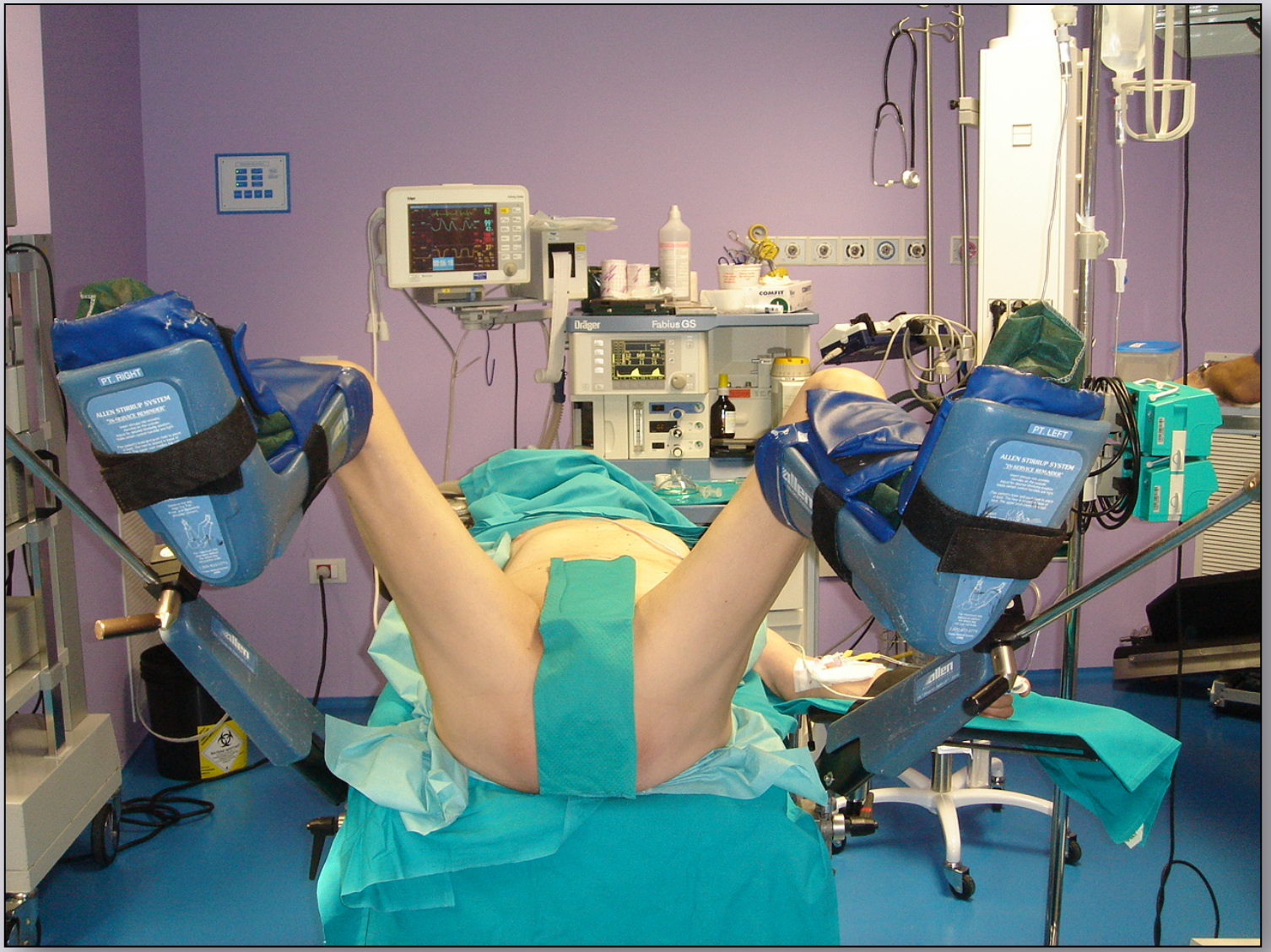
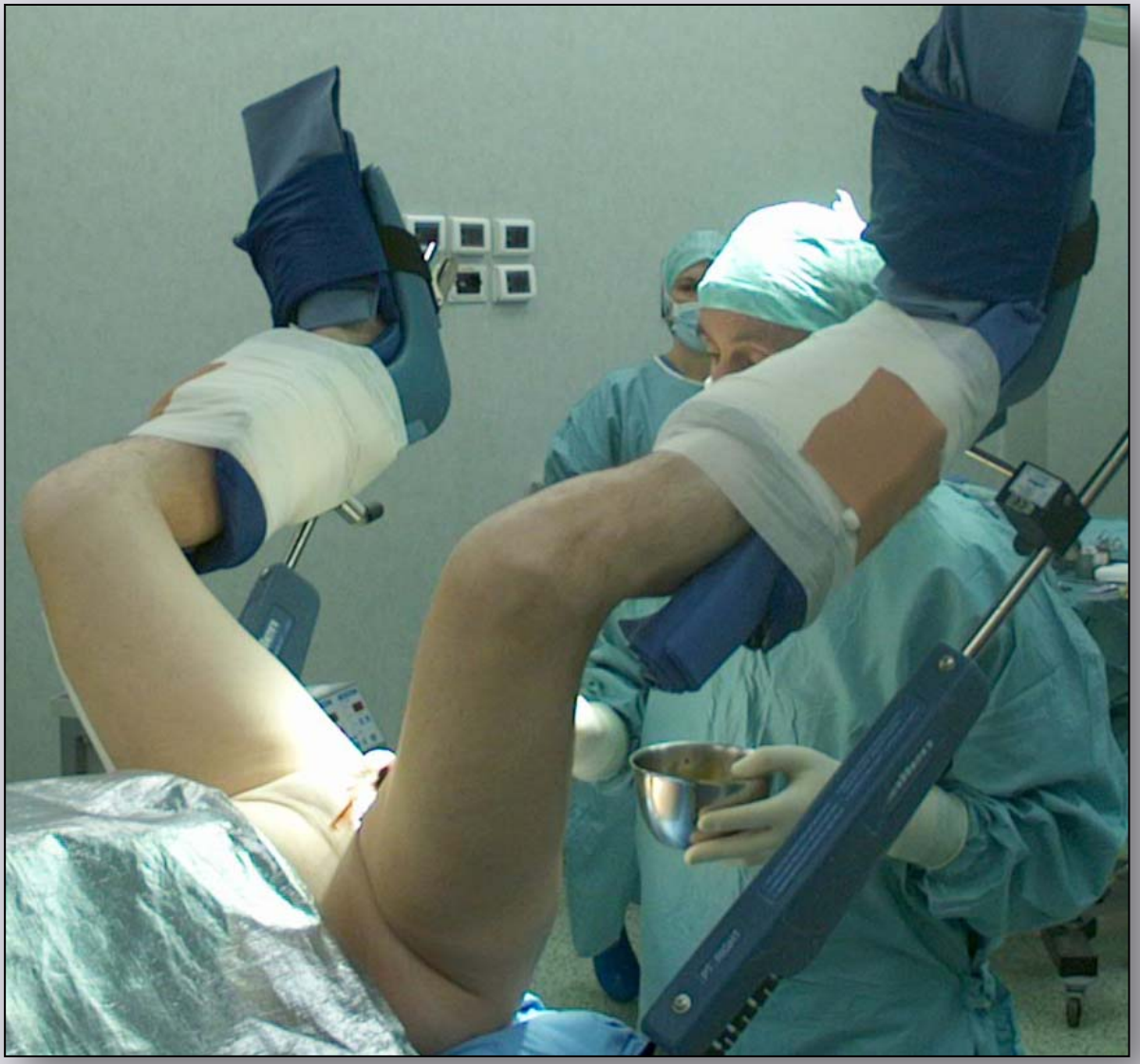
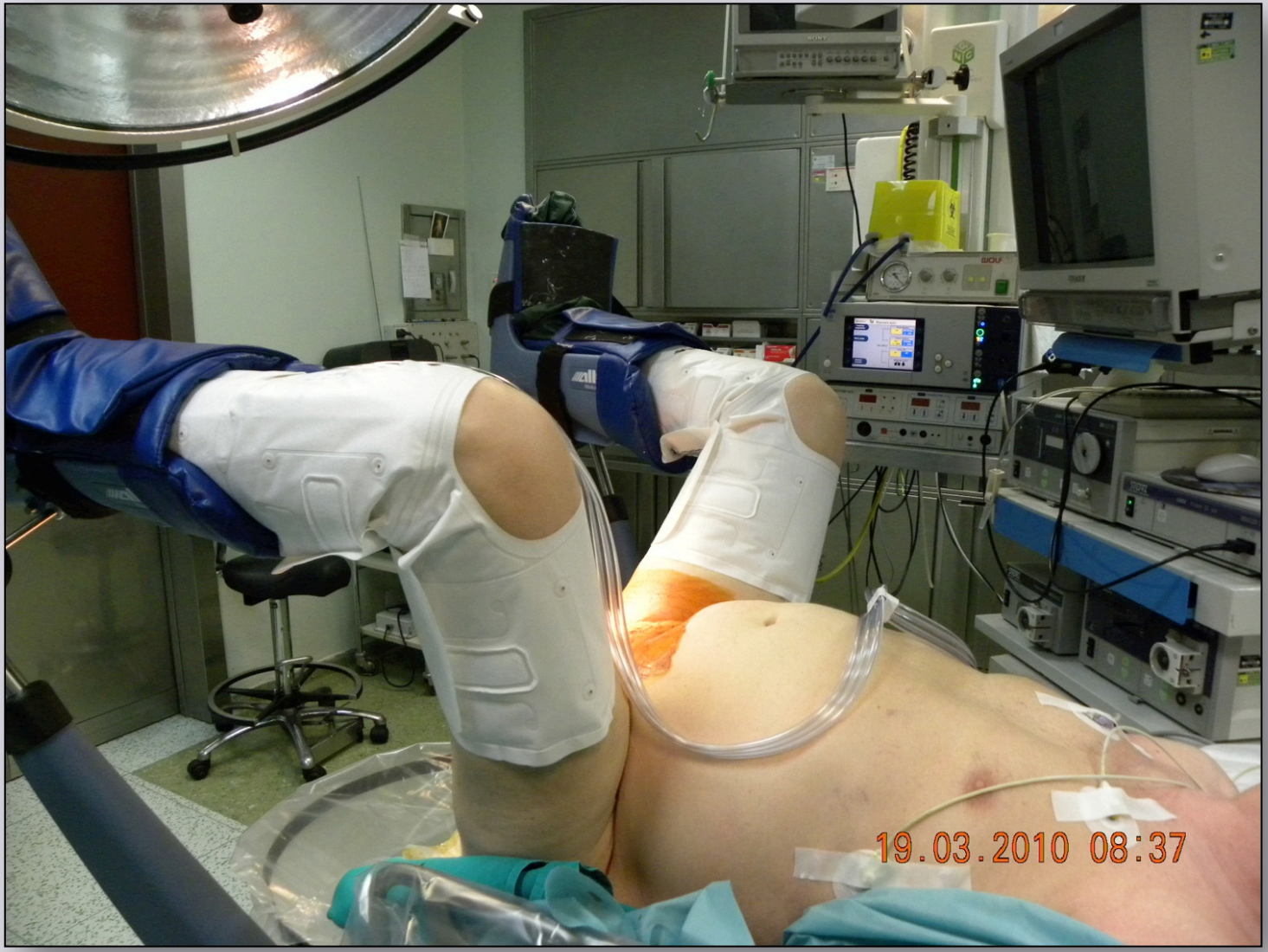


Simple lithotomy position



Allen’s stirrups



Sequential inflatable compression sleeves

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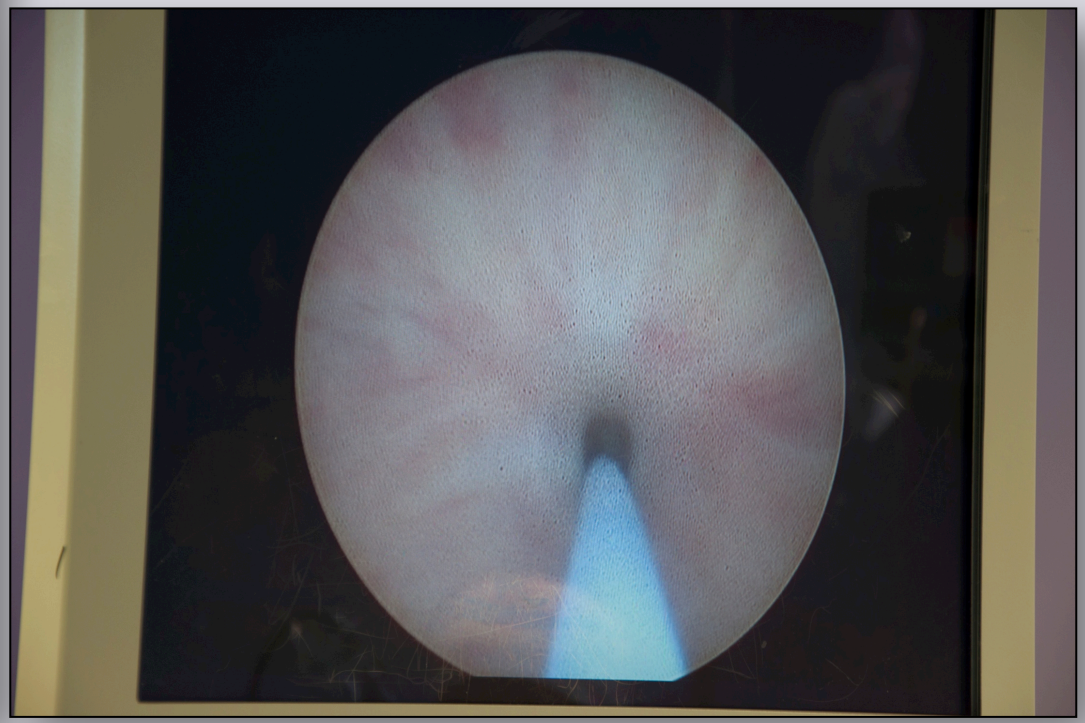
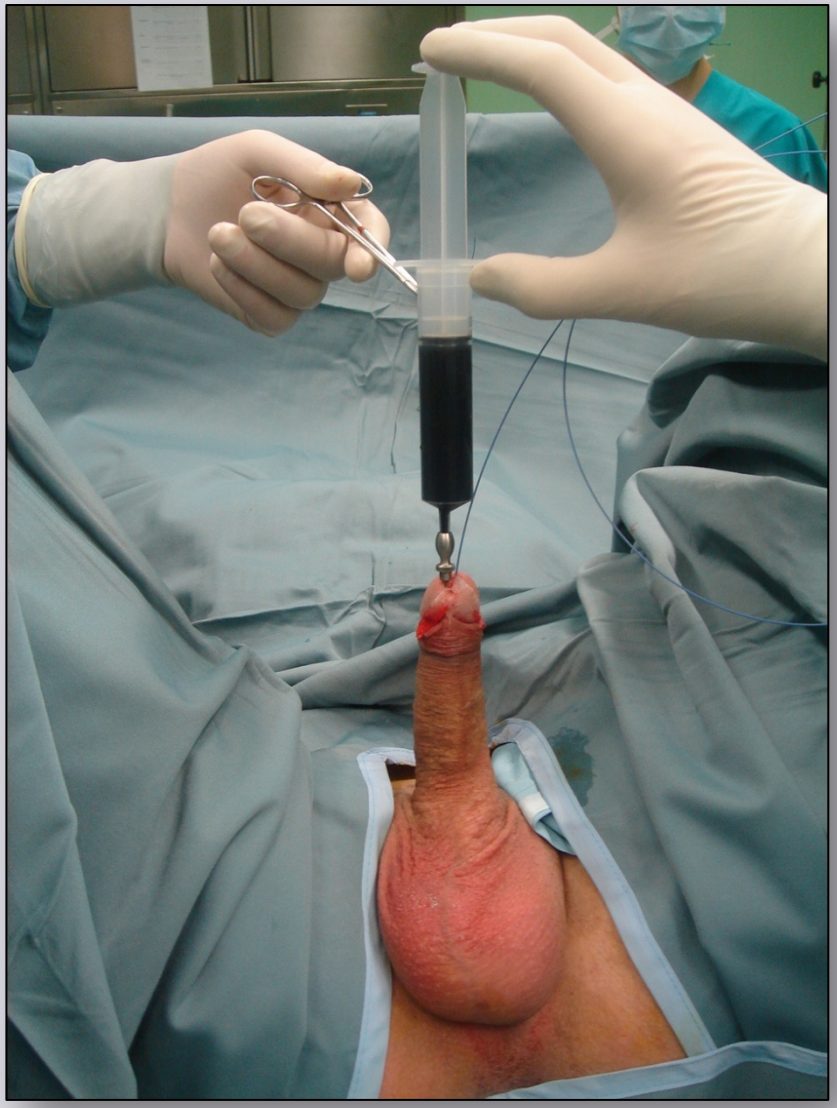
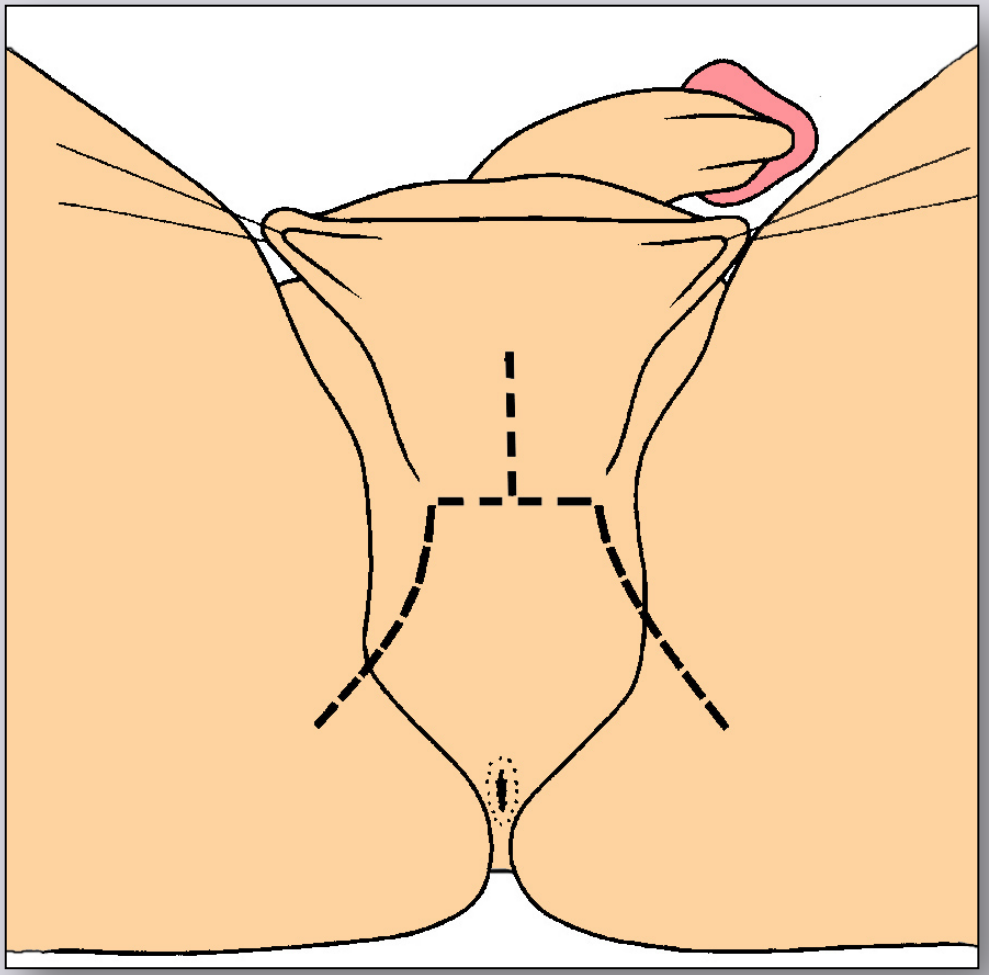


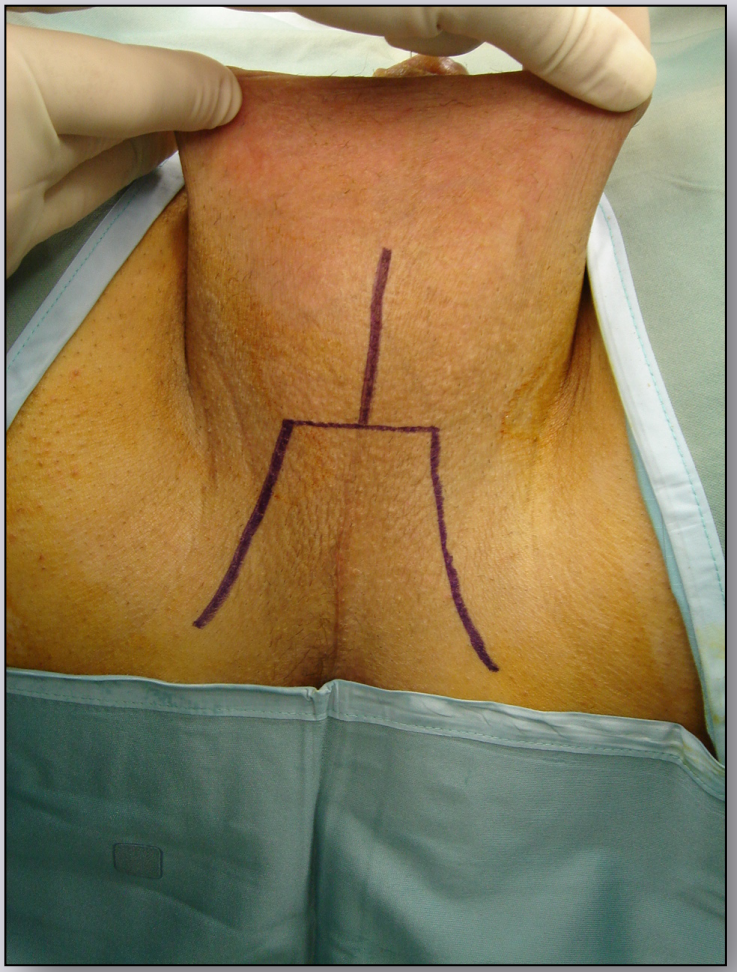
Insert 3 Fr. Sensor guidewire



Inject methylene blue inside the urethra

(G. Webster)





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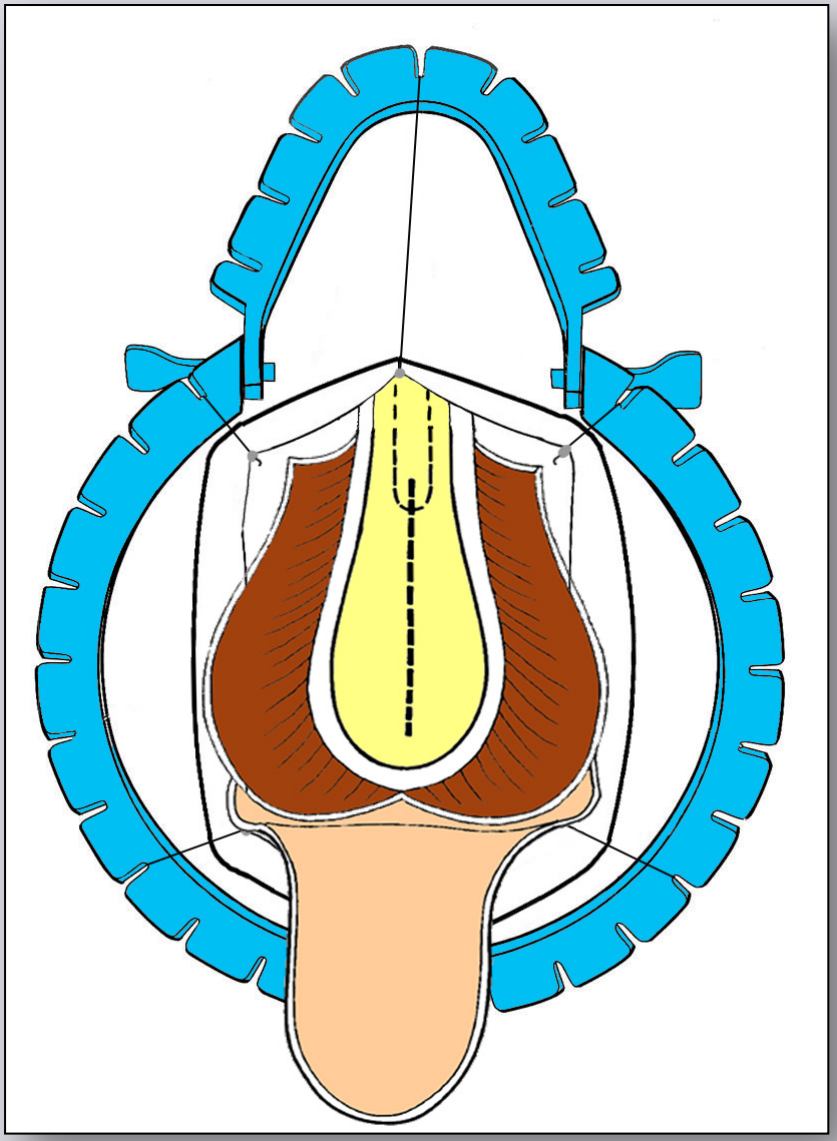

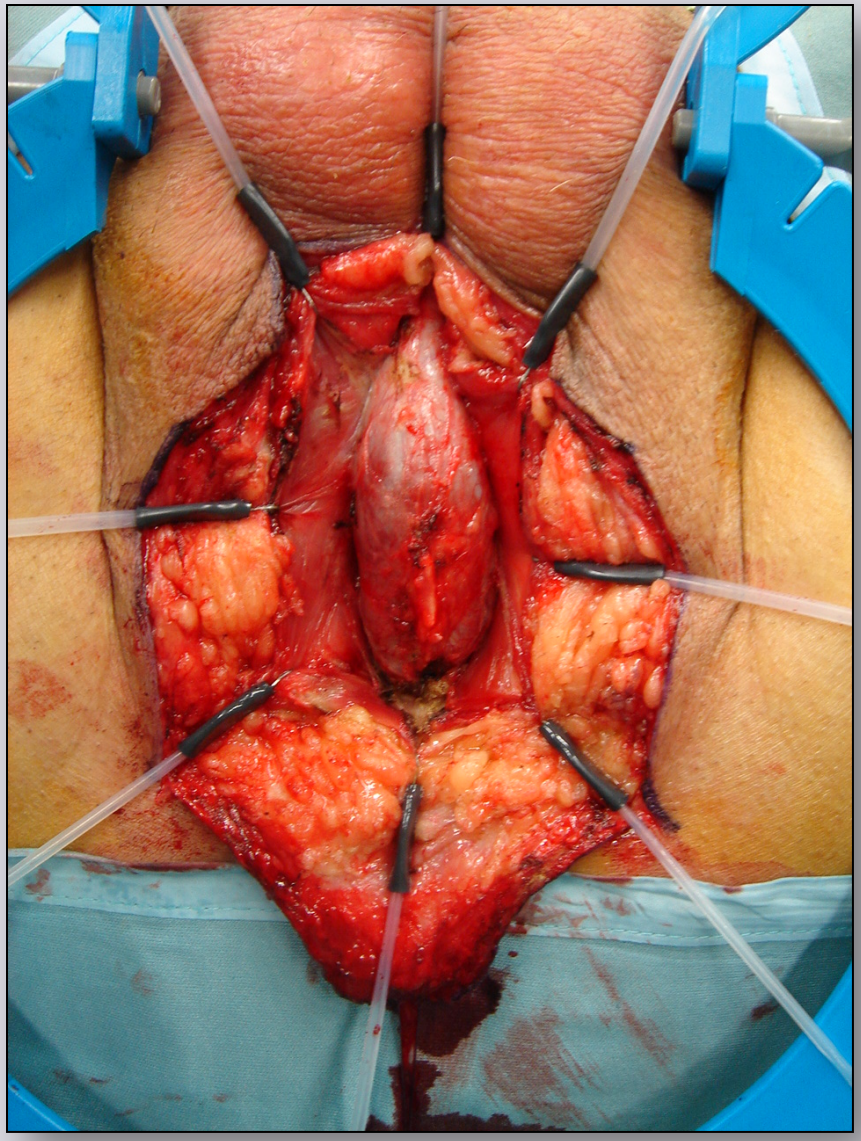

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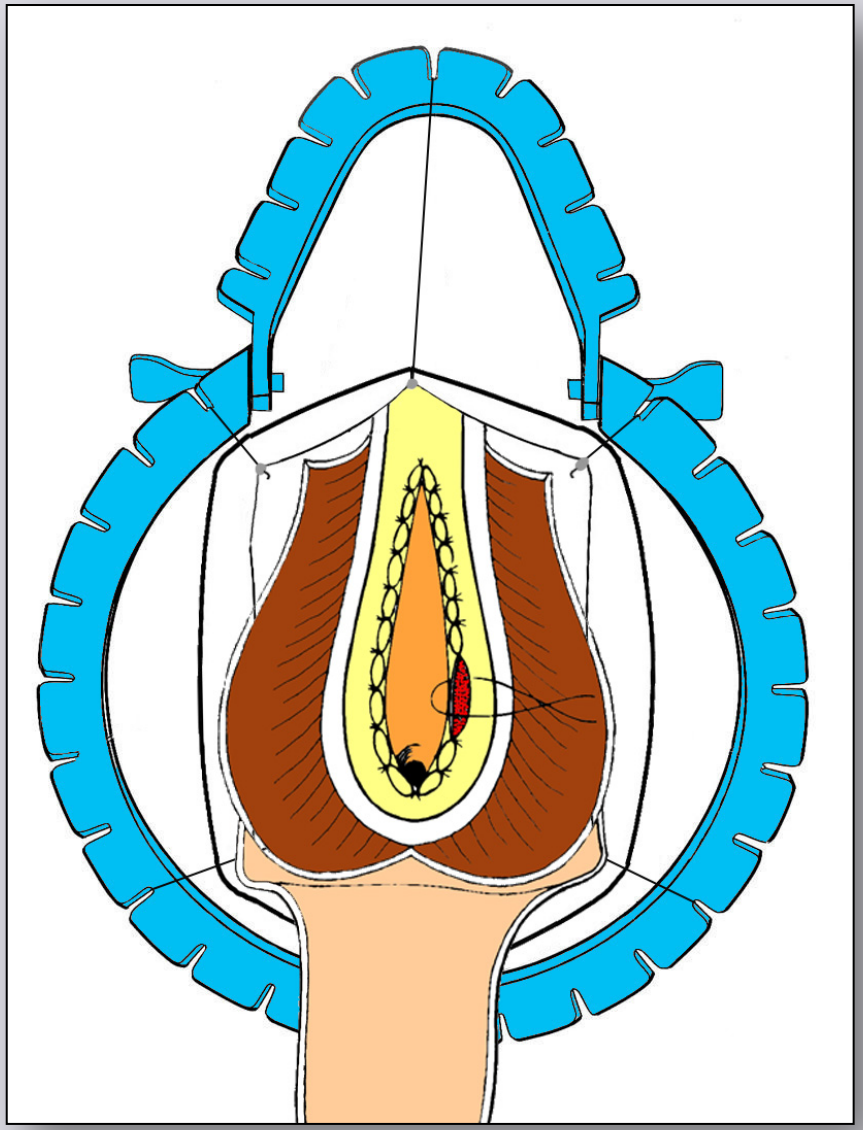

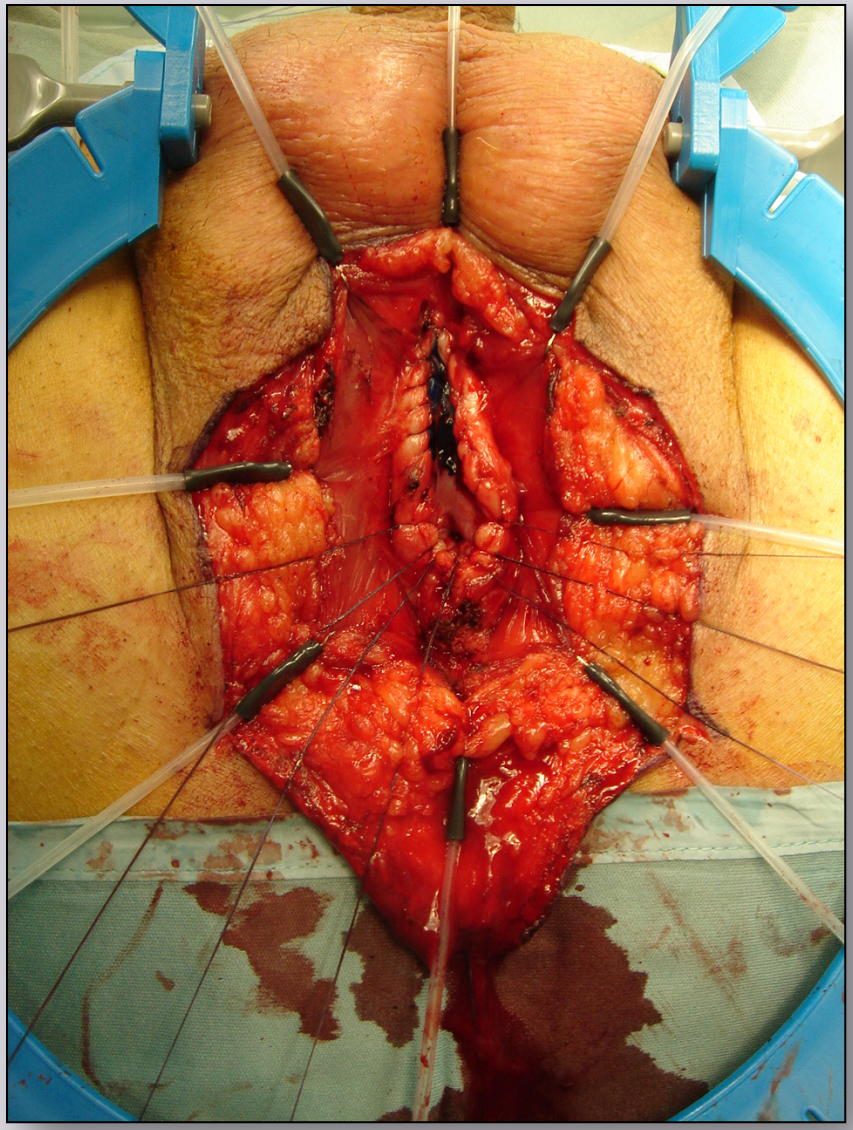

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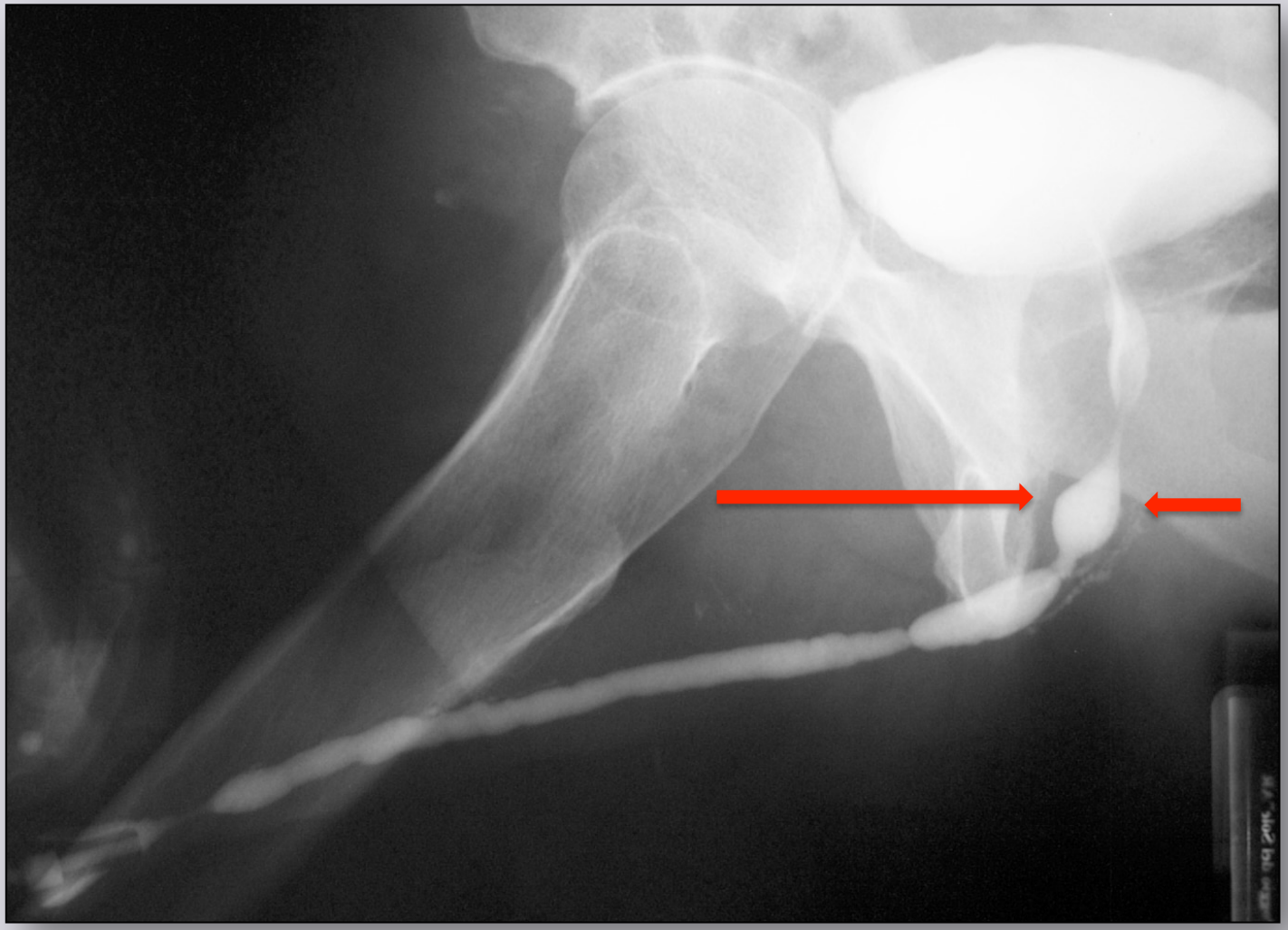

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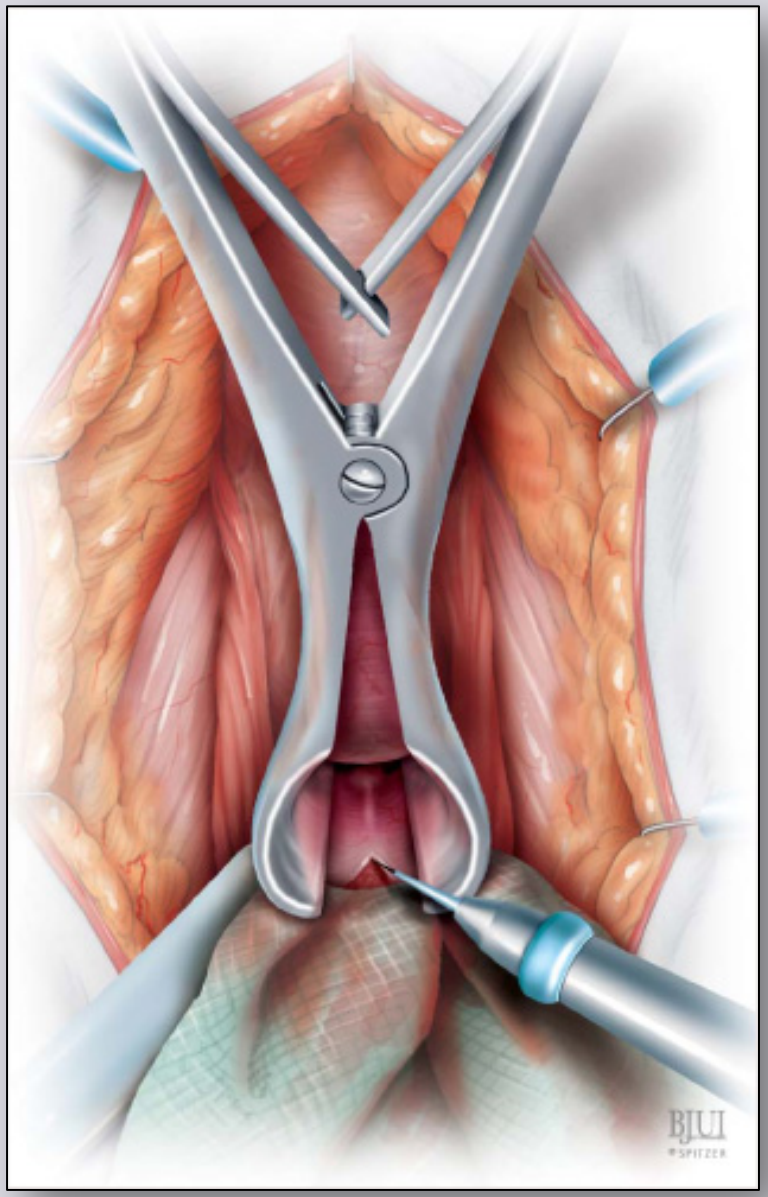

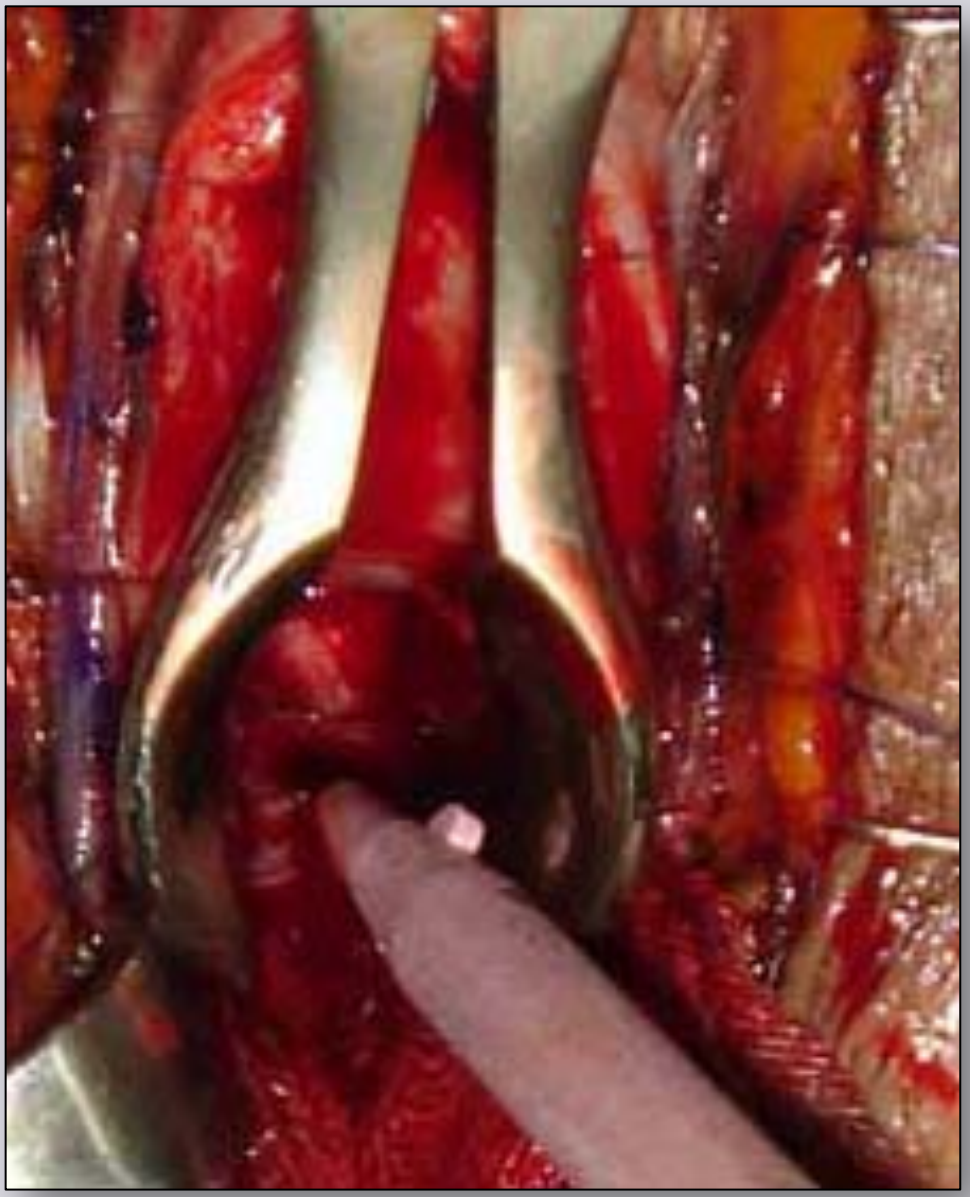

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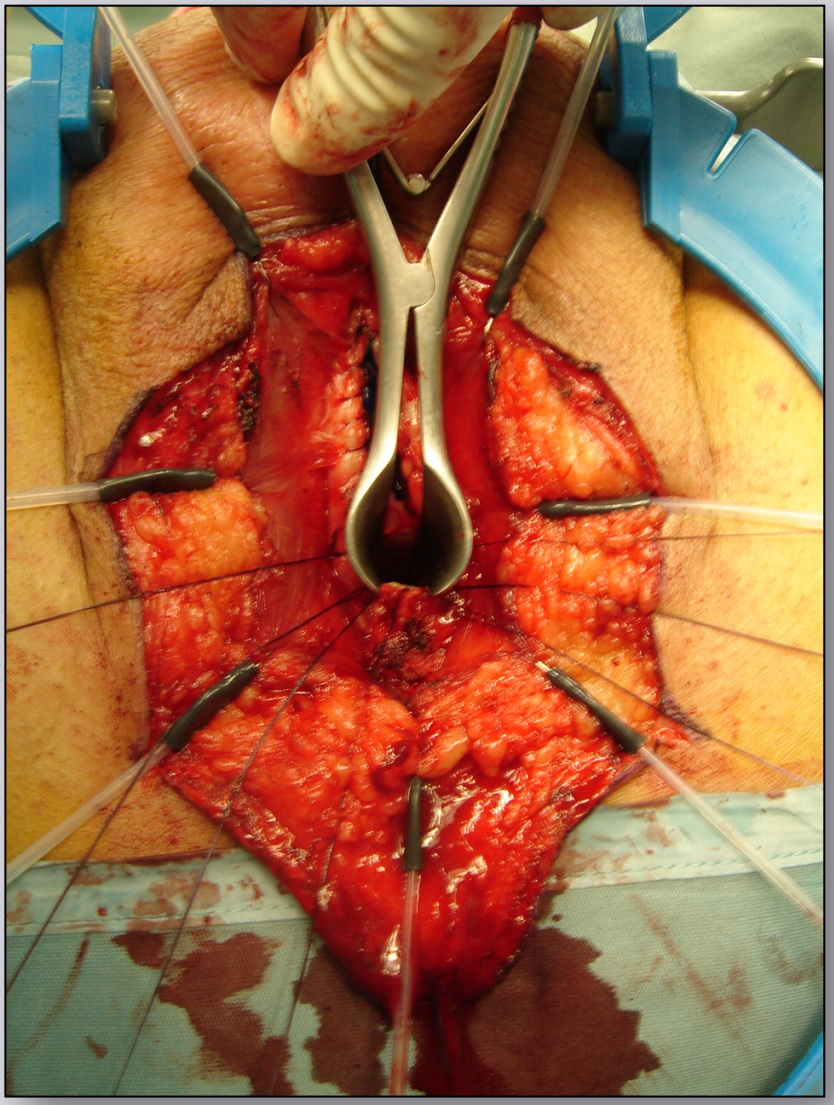

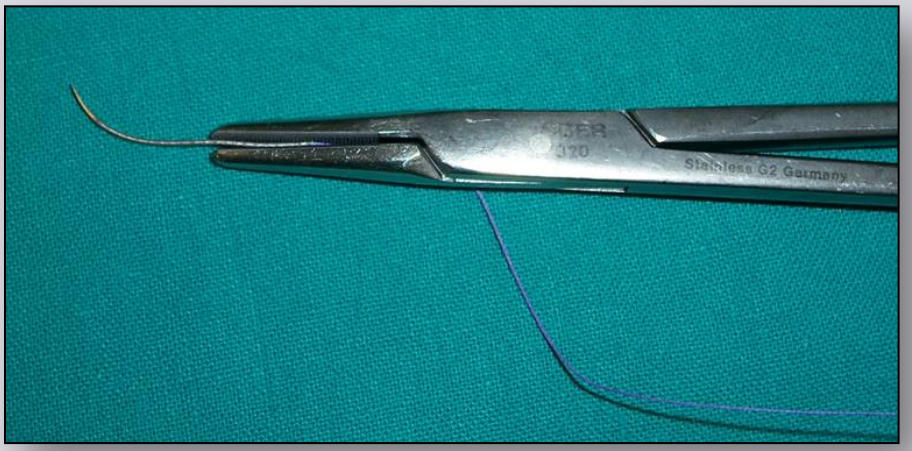

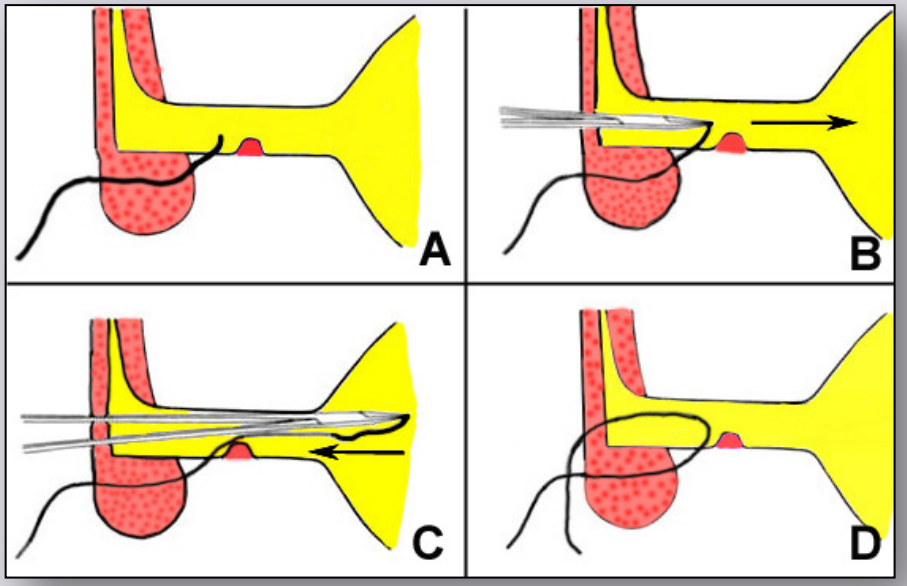

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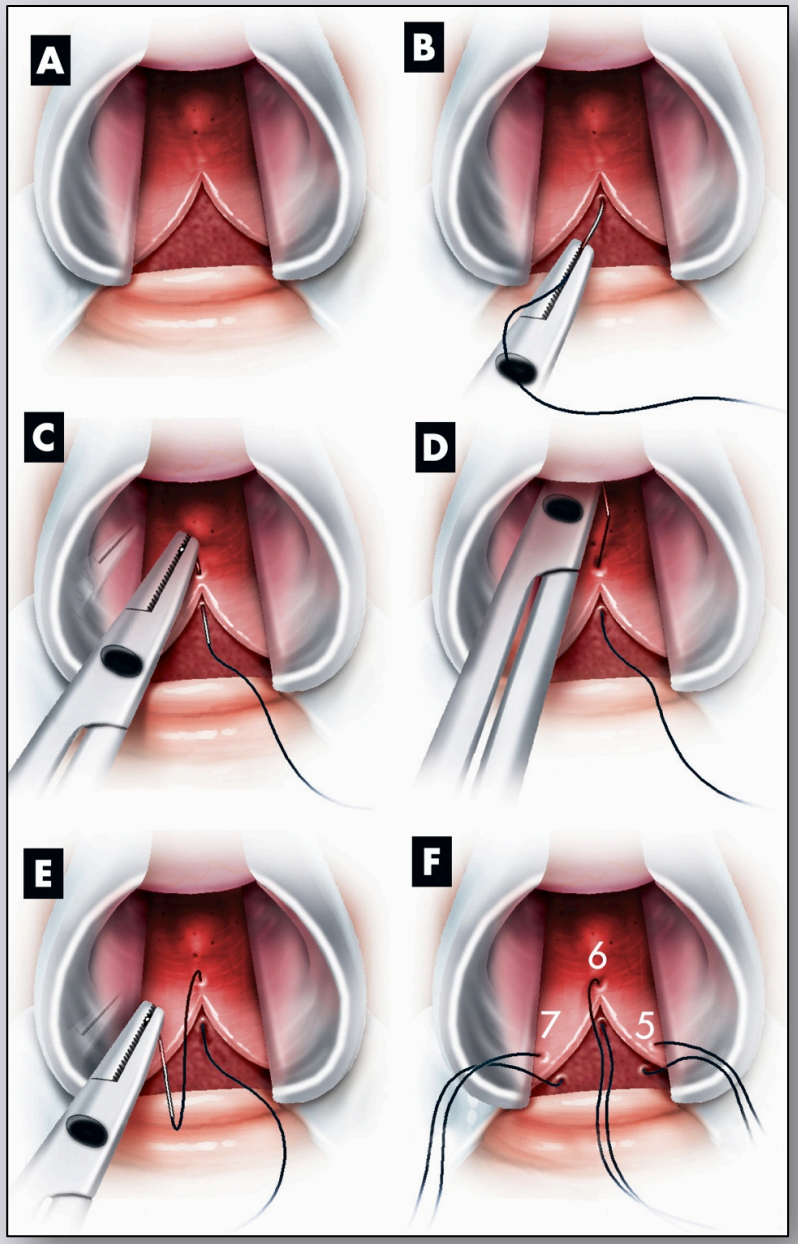

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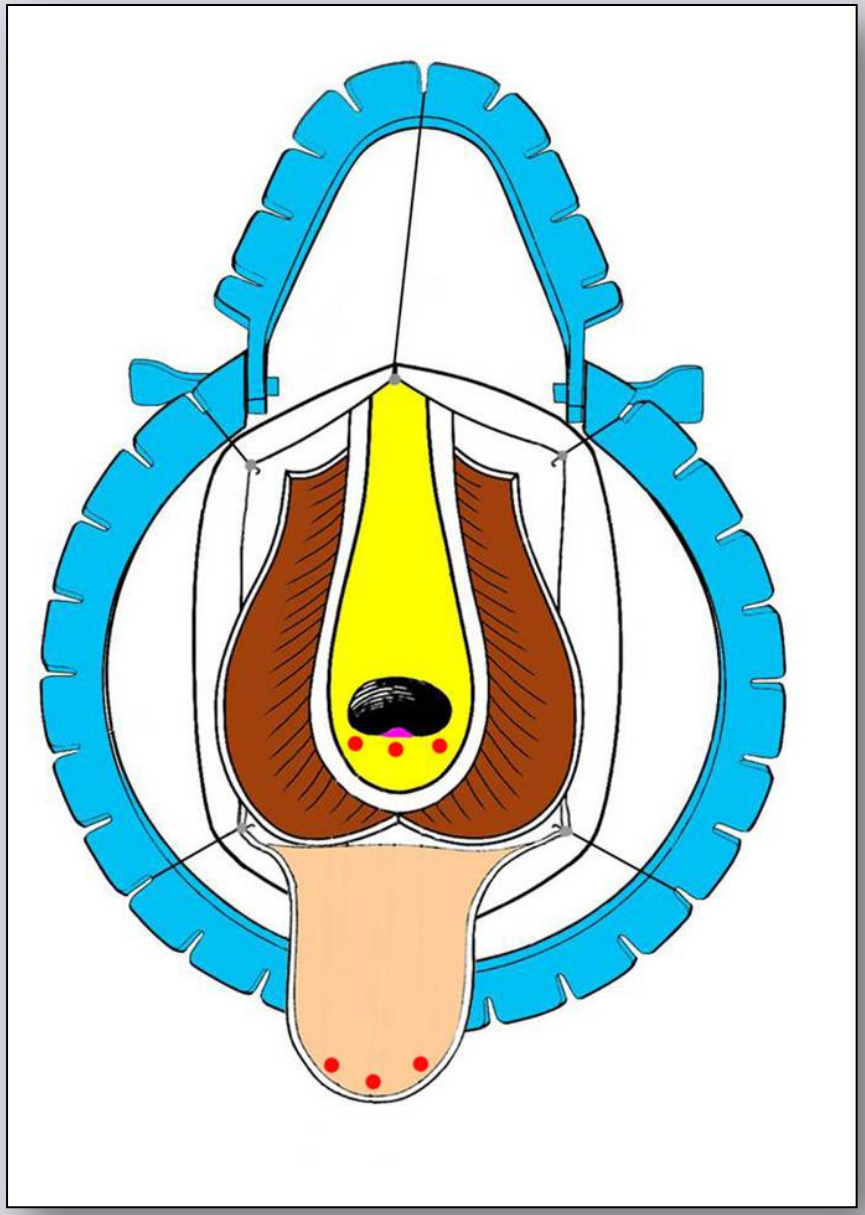

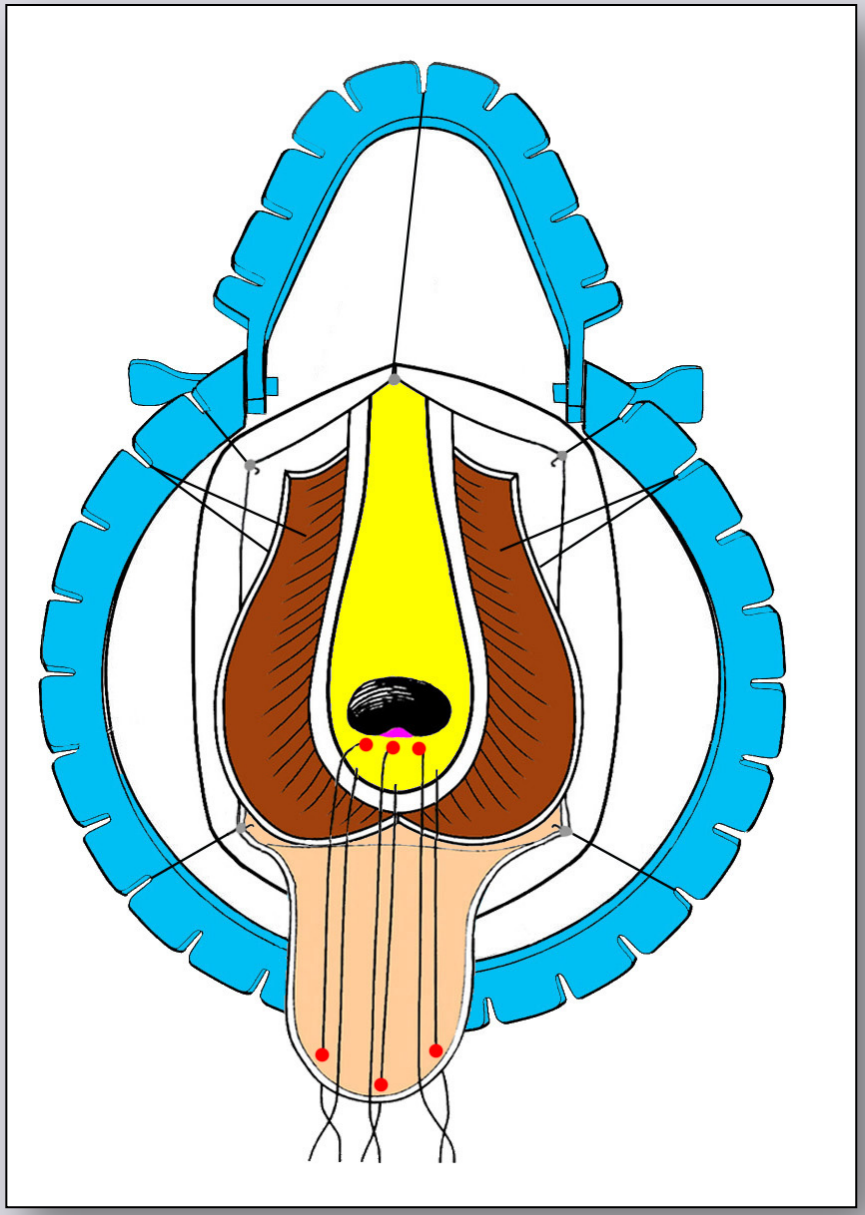

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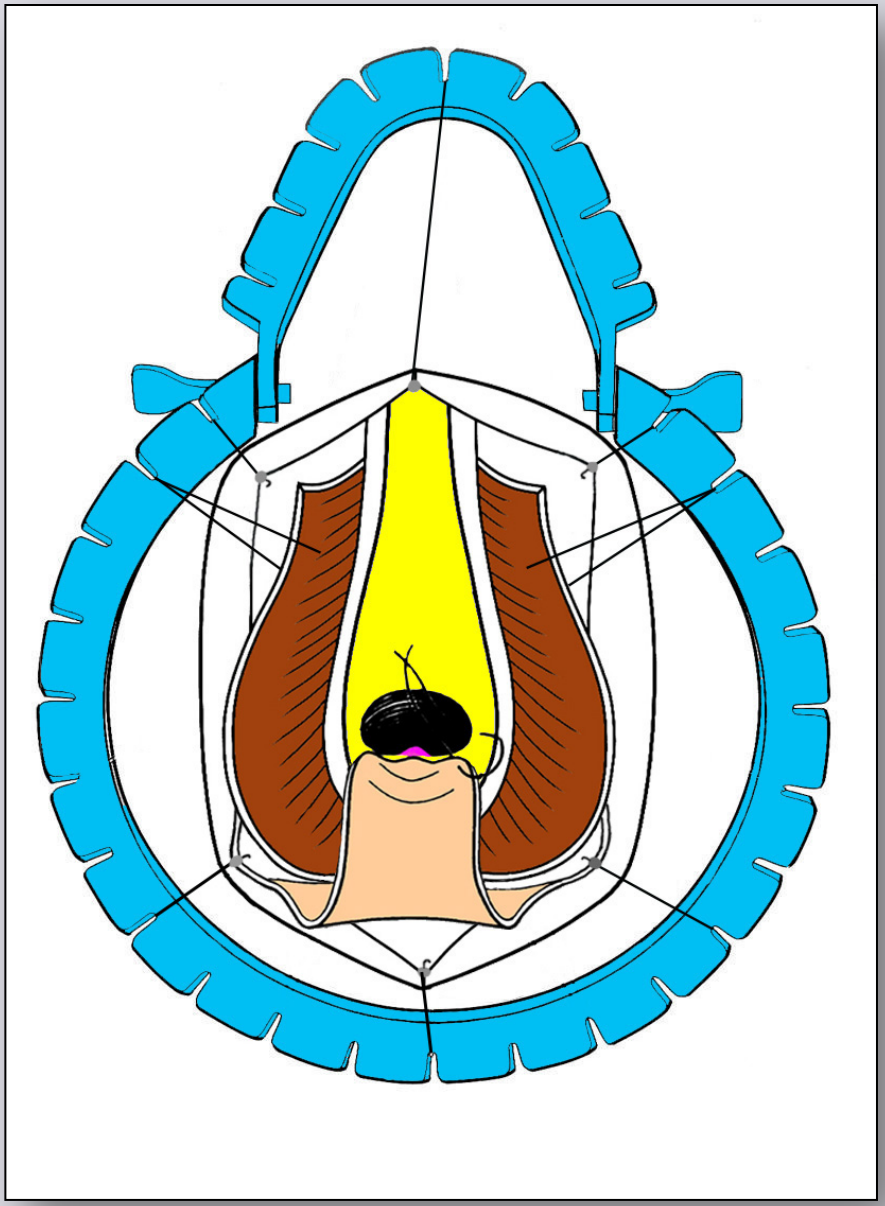

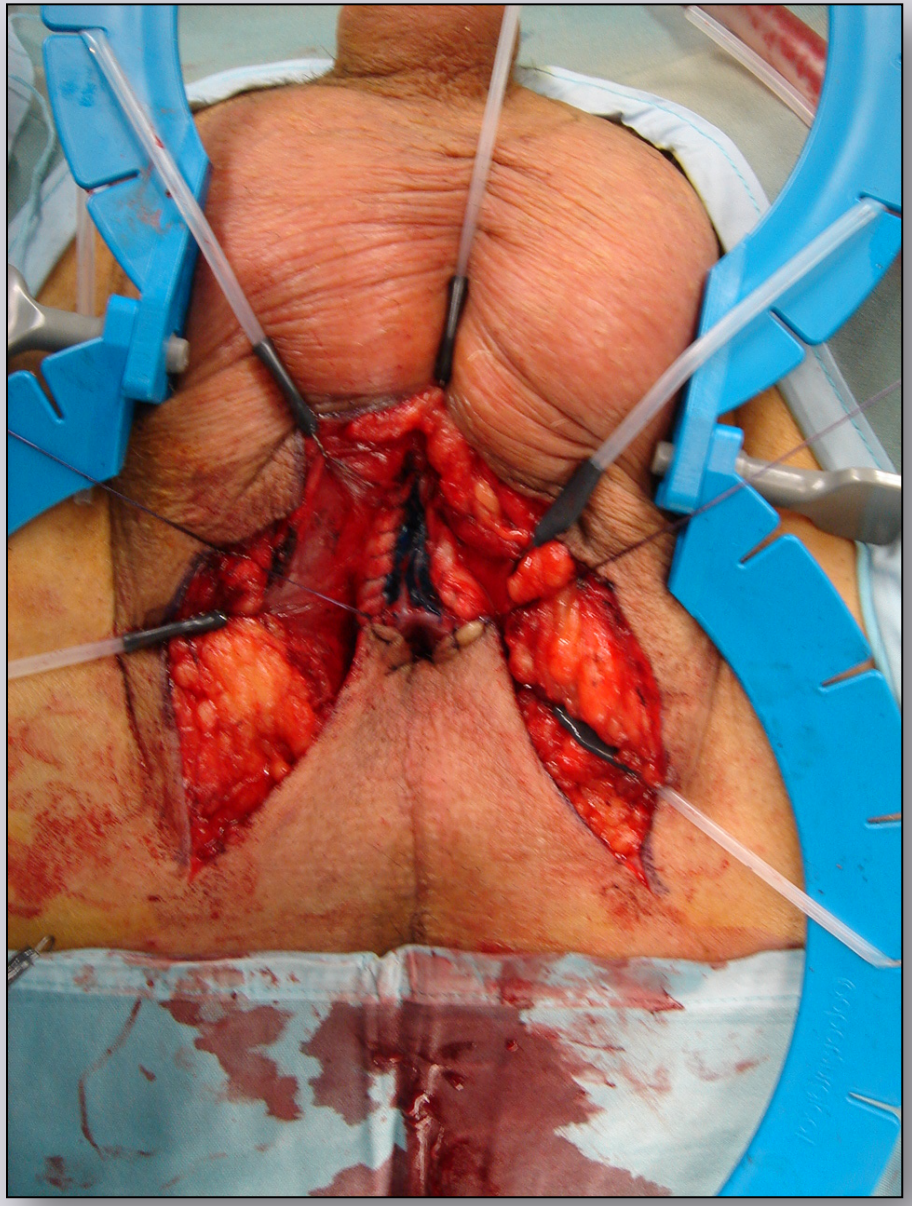

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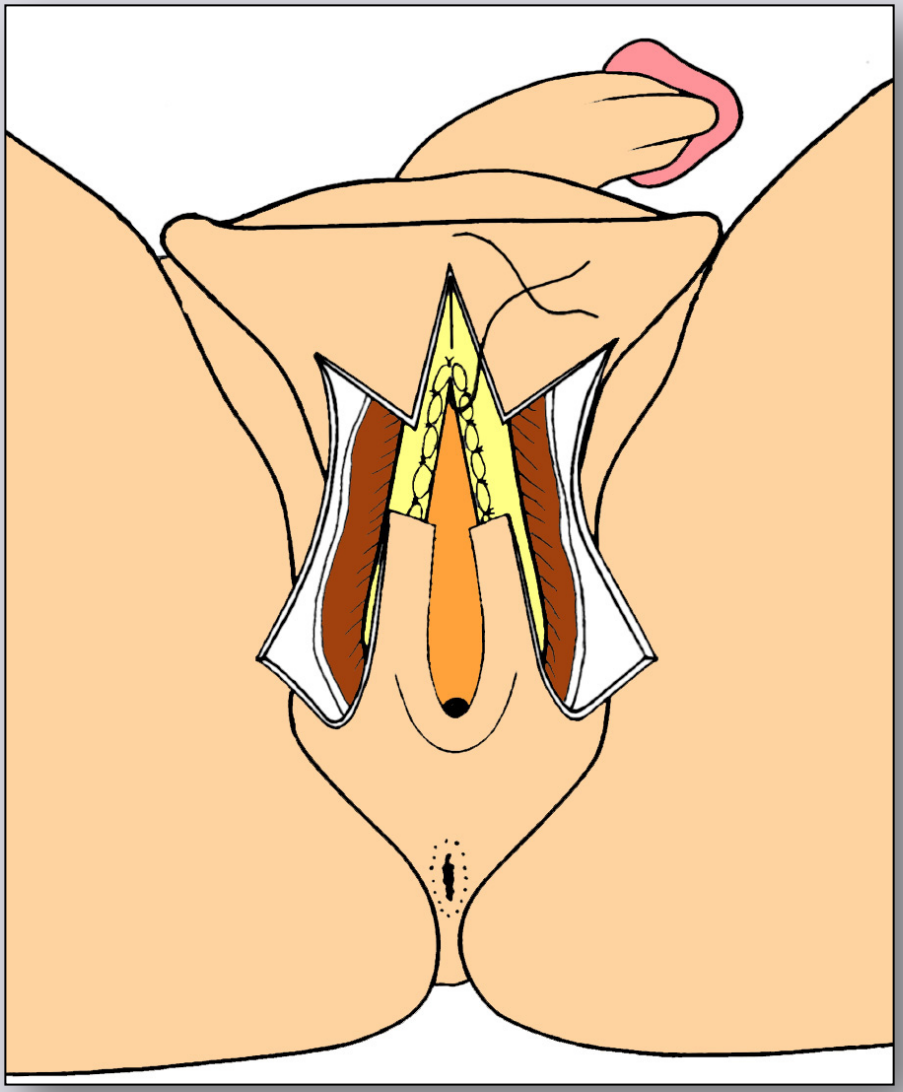

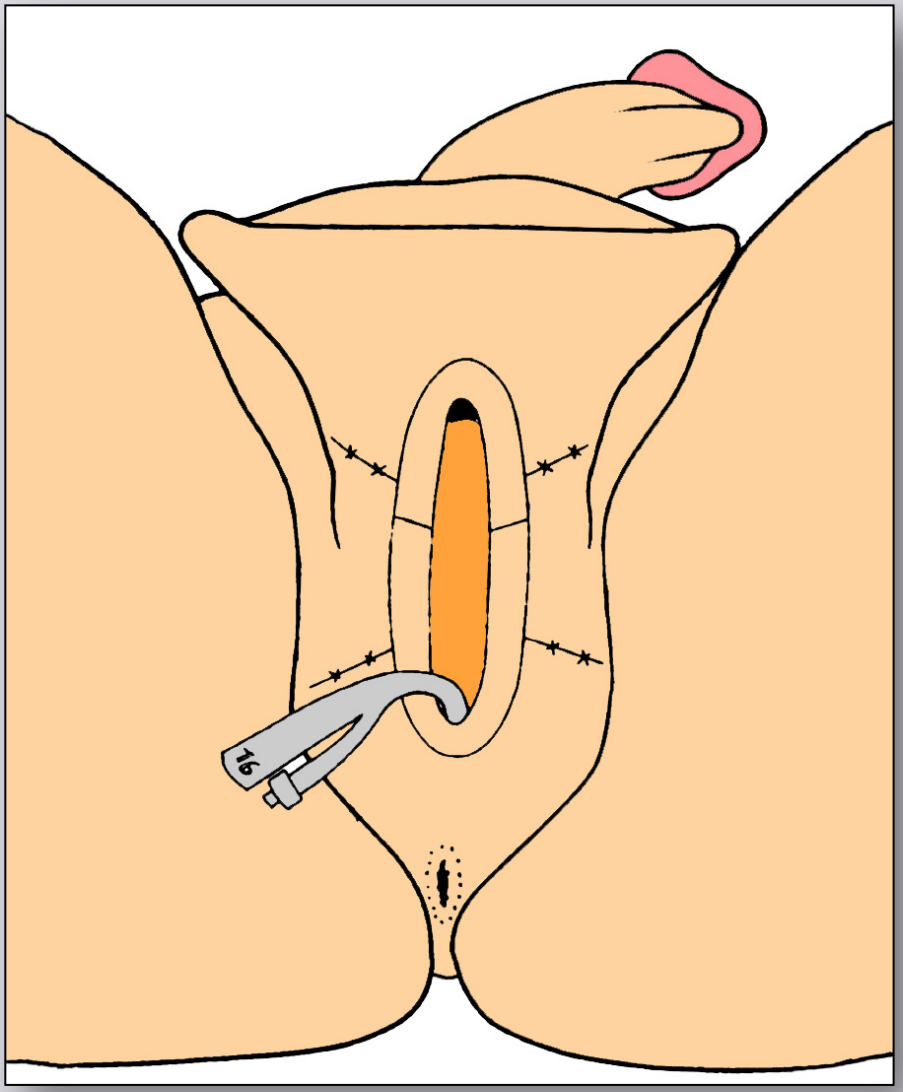

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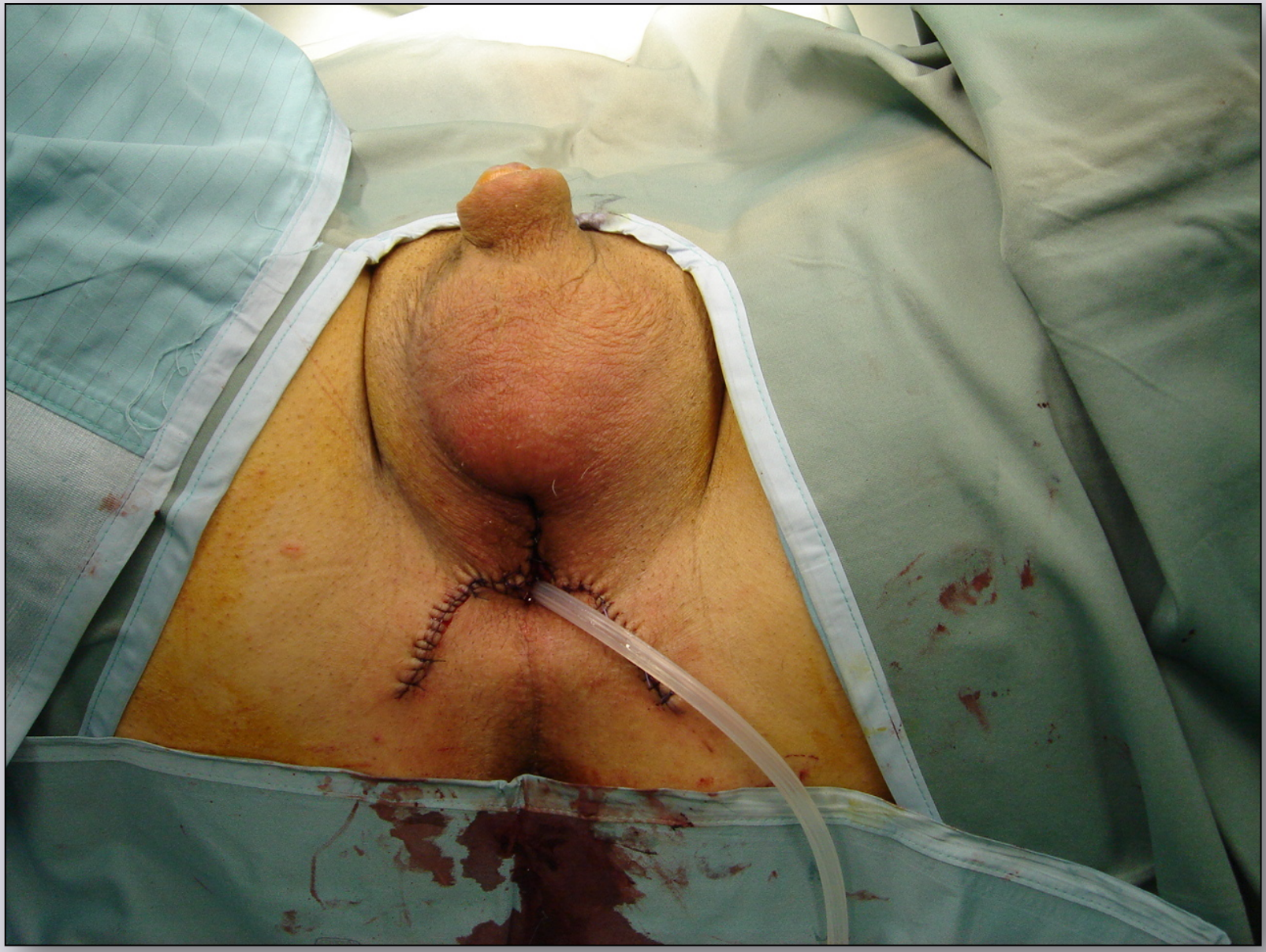

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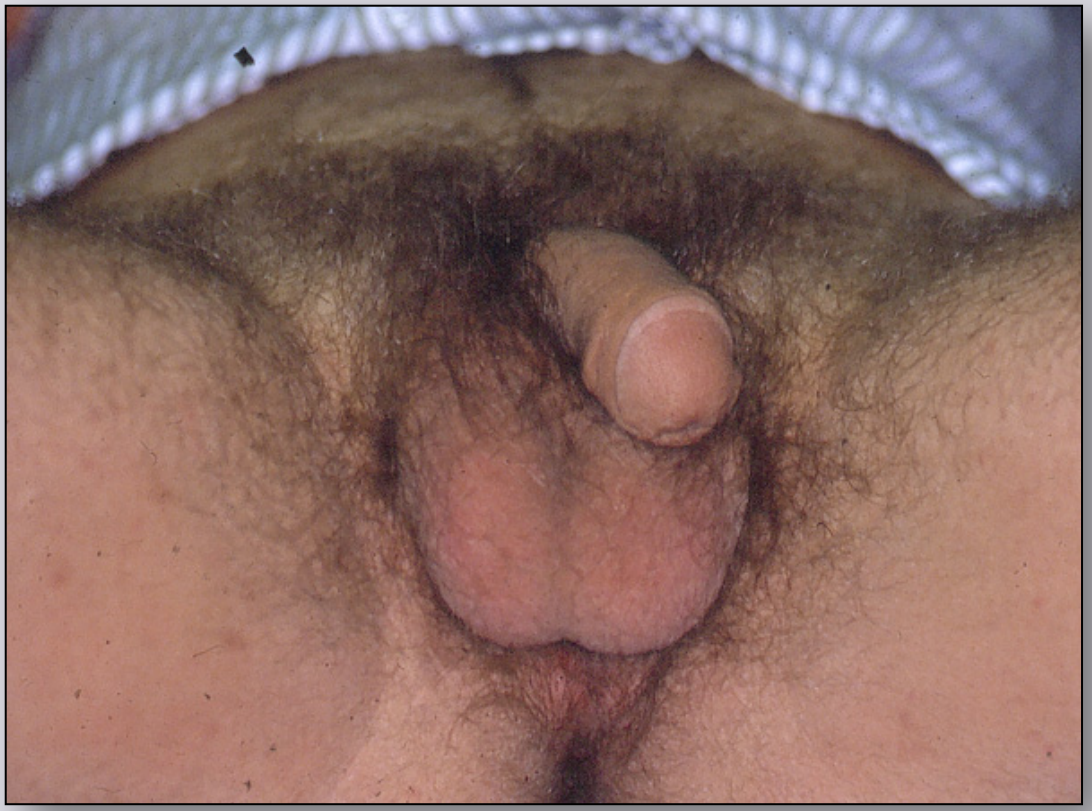

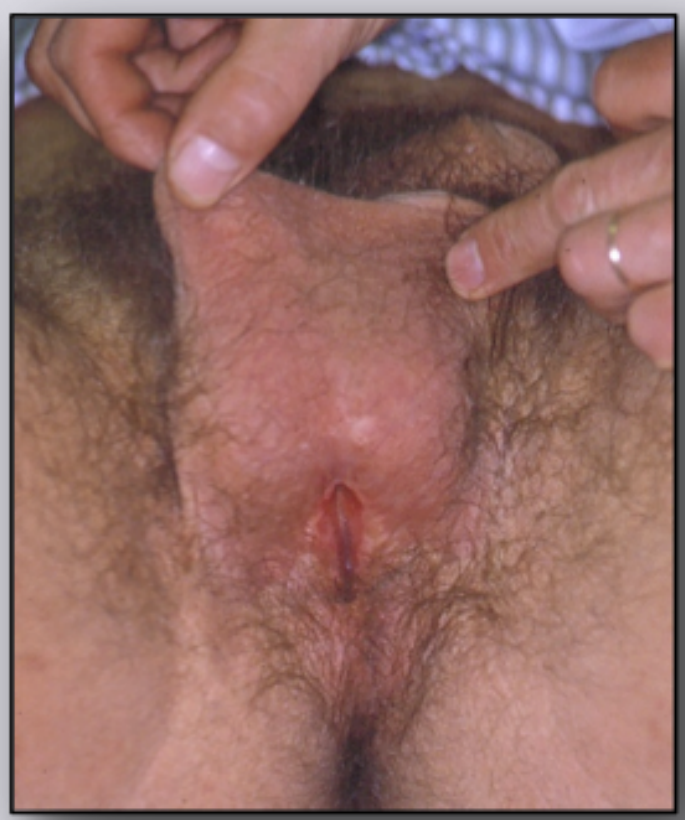

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Clinical Outcome and Quality of Life Assessment in Patients Treated With Perineal Urethrostomy for Anterior Urethral Stricture Disease

Guido Barbagli, Michele De Angelis, Giuseppe Romano and Massimo Lazzeri*

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J Urol 2009: 182; 548-557

Table 8. *Patient satisfaction according to clinical outcome and median followup*

	No. Pts (%)	No. Successes (%)	No. Failures (%)	Median Mos Followup (range)
Dissatisfied	2 (1.2)	1 (50)	1 (50)	59.5 (25–94)
Little satisfied	3 (1.7)	1 (33.3)	2 (66.7)	96 (15–97)
Satisfied	135 (78)	93 (68.9)	42 (31.1)	61 (12–281)
Very satisfied	33 (19.1)	26 (78.8)	7 (21.2)	77 (12–361)
Totals	173 (100)	121 (70)	52 (30)	

J Urol 2009: 182; 548-557

“ Would you undergo this type of operation again”

YES: 168 patients (97.1%)

NO: 5 patients (2.9%)

“ Would you like to undergo second stage urethroplasty to restore normal urinary function? “

NO: 127 patients (73.4%)

YES: 46 patients (26.6%%)

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