

CENTER FOR RECONSTRUCTIVE URETHRAL SURGERY



GUIDO BARBAGLI, M.D.
Arezzo - Italy

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CRU16

II Meeting of the Spanish Group of Genitourinary Reconstructive Surgery

In collaboration with the EAU Section of Genito-Urinary Reconstructive Surgeons



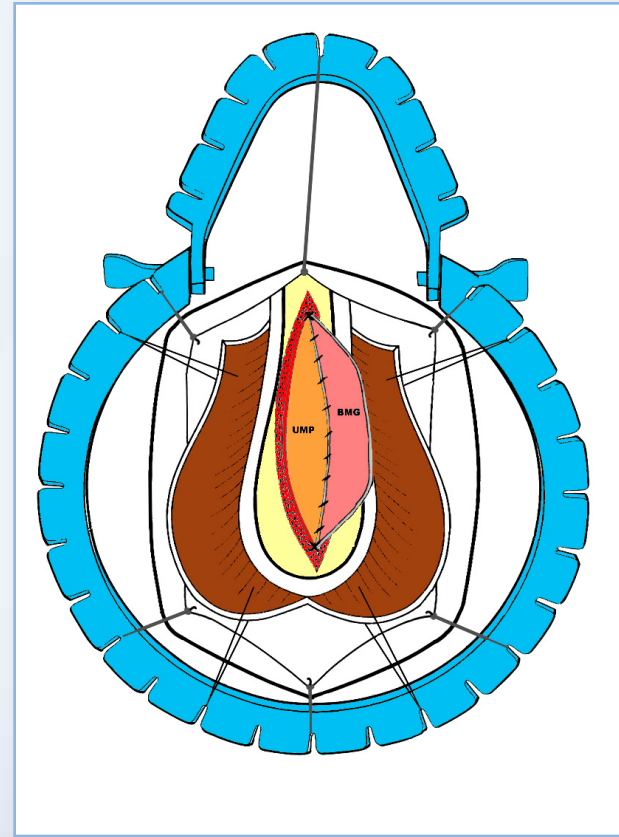
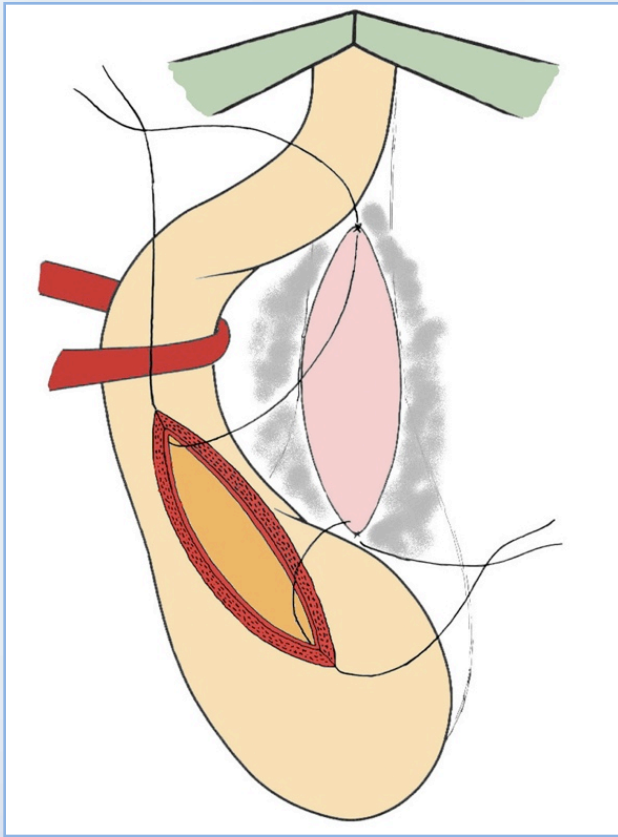
7 – 8 October 2016



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The evolution from dorsal free graft urethroplasty to ventral free graft urethroplasty in bulbar stricture.



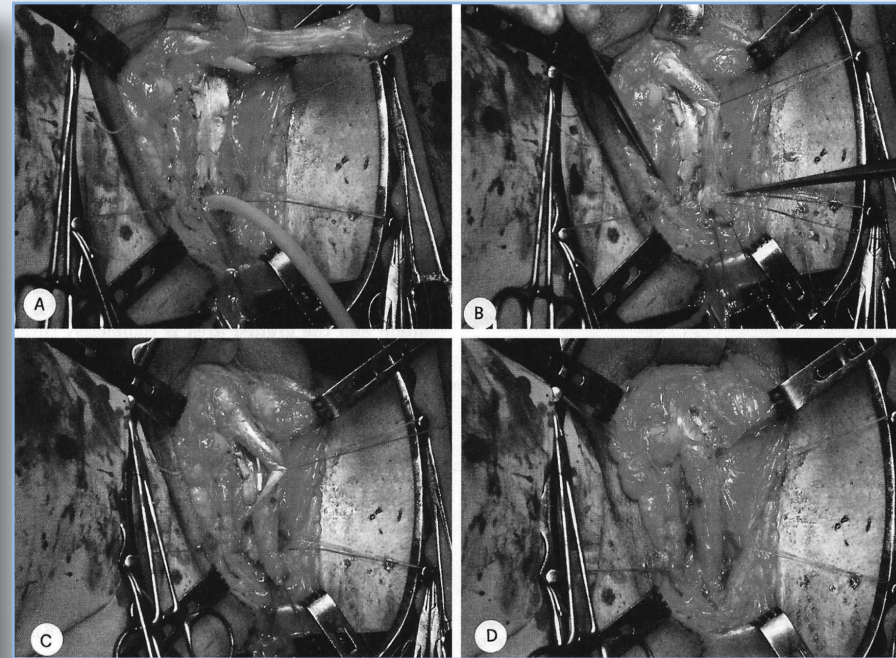
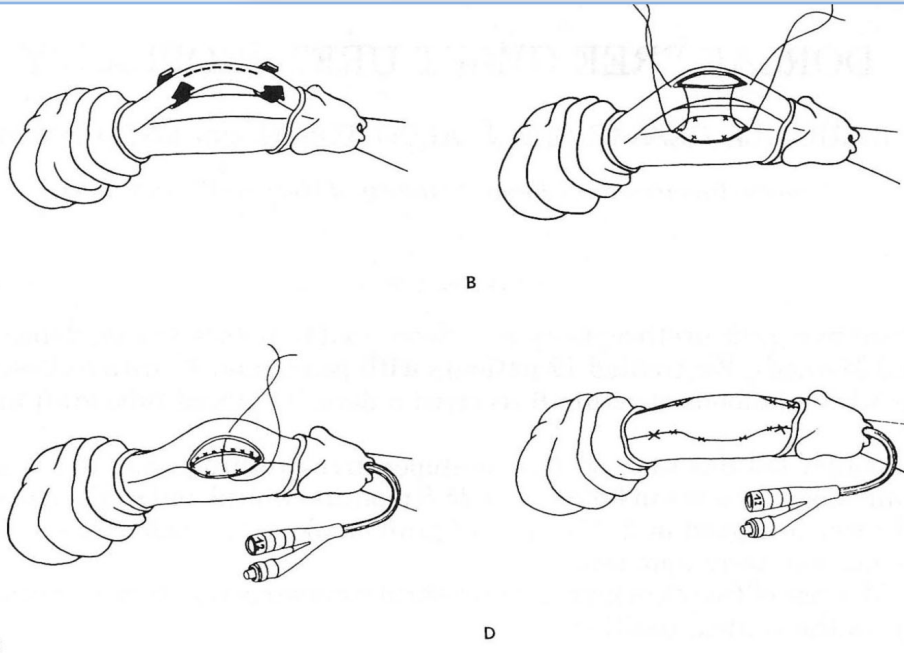
AVOIDING COMPLICATIONS IN BULBAR URETHROPLASTY



DORSAL FREE GRAFT URETHROPLASTY

GUIDO BARBAGLI, CESARE SELLI, ALDO TOSTO AND ENZO PALMINTERI

From the Department of Urology, University of Florence, Florence, Italy



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Ventral Oral Mucosal Onlay Graft Urethroplasty in Nontraumatic Bulbar Urethral Strictures: Surgical Technique and Multivariable Analysis of Results in 214 Patients


Guido Barbagli^a, Francesco Montorsi^b, Giorgio Guazzoni^b, Alessandro Larcher^b, Nicola Fossati^b, Salvatore Sansalone^a, Giuseppe Romano^a, Nicolòmaria Buffi^b, Massimo Lazzeri^{b,}*

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Eur Urol 2013; 64: 440-447



Dorsal **or** Ventral oral graft urethroplasty in
bulbar stricture?



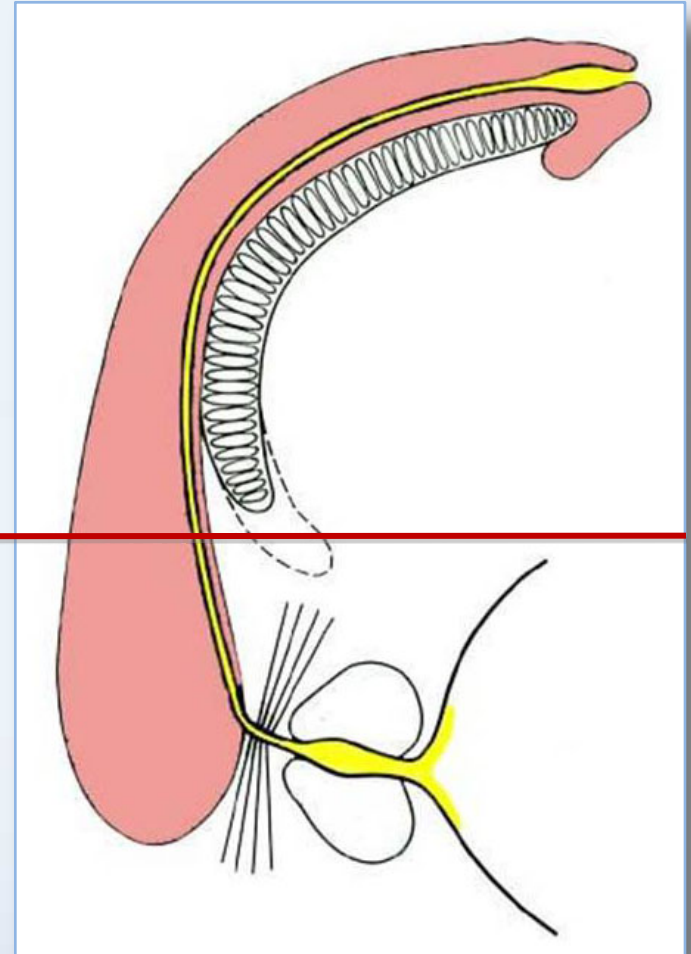
Dorsal **and** Ventral oral graft
urethroplasty in bulbar stricture !



Ventral or dorsal graft?

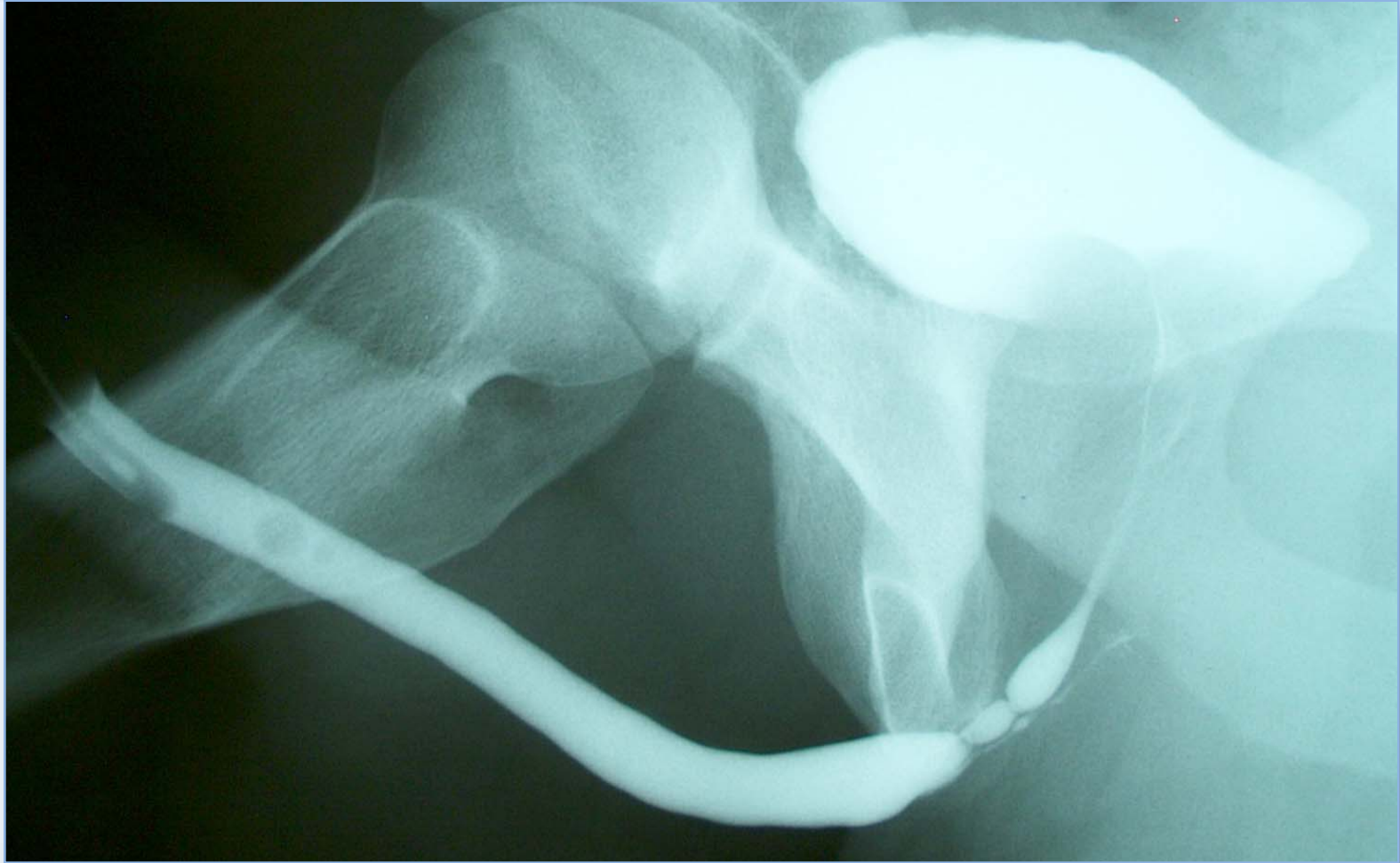


Distal
Dorsal onlay



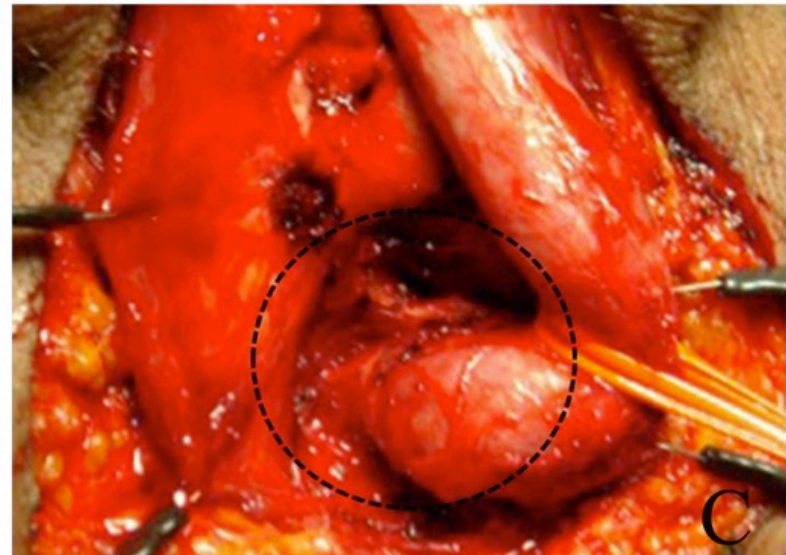
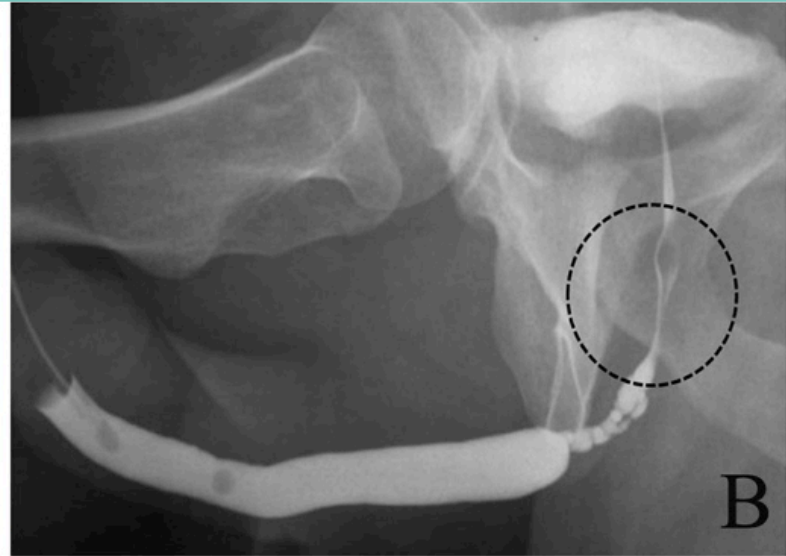
Proximal
Ventral onlay



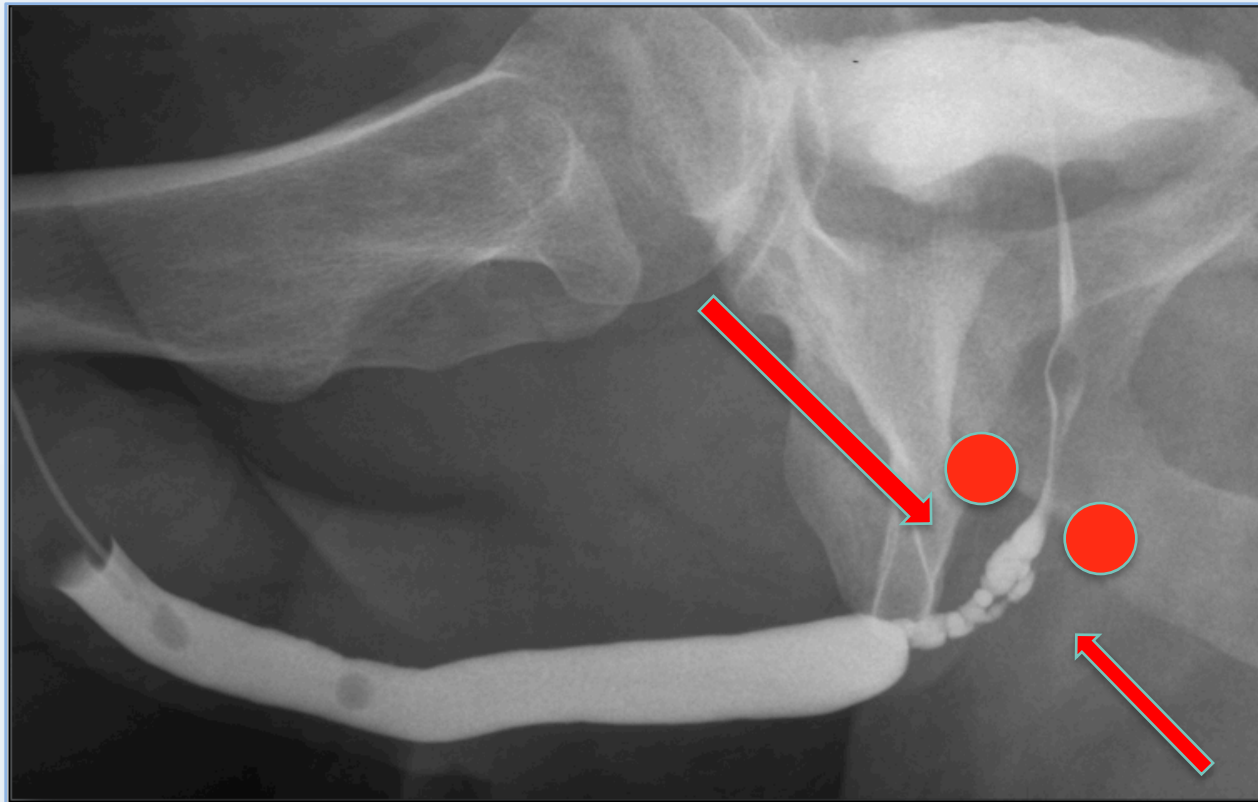


Idiopathic, 2-4 cm, recurrent after urethrotomy





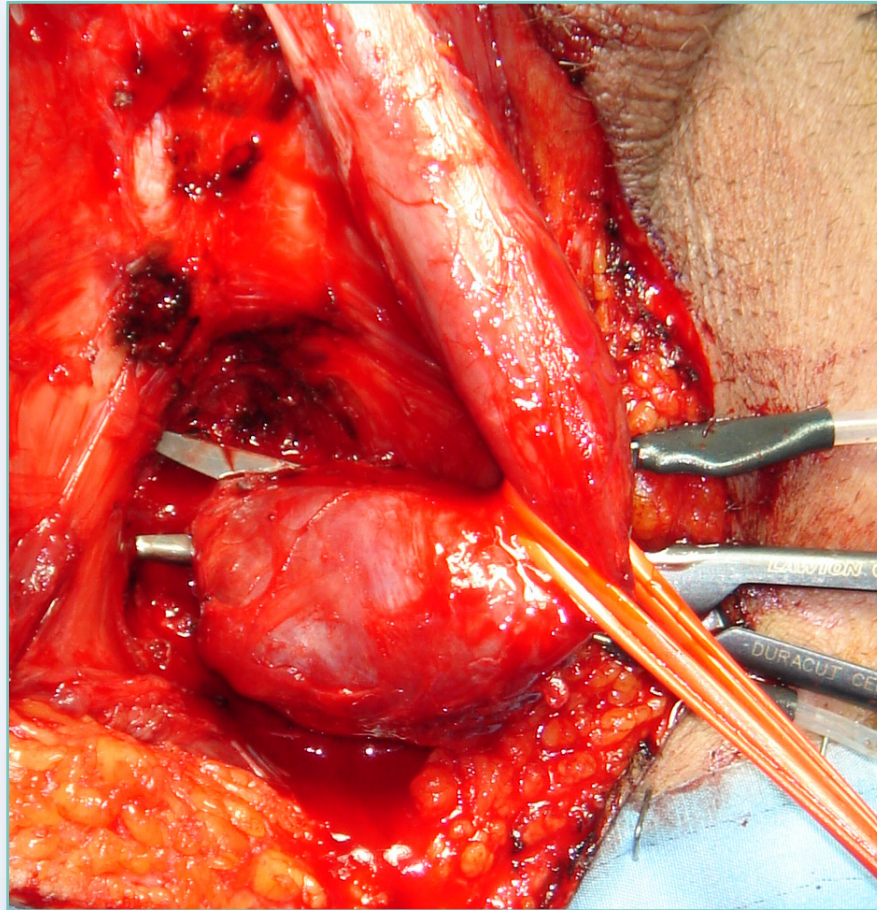
Bulbar urethroplasty



**Working around urethra may damage
innervation and blood supply**



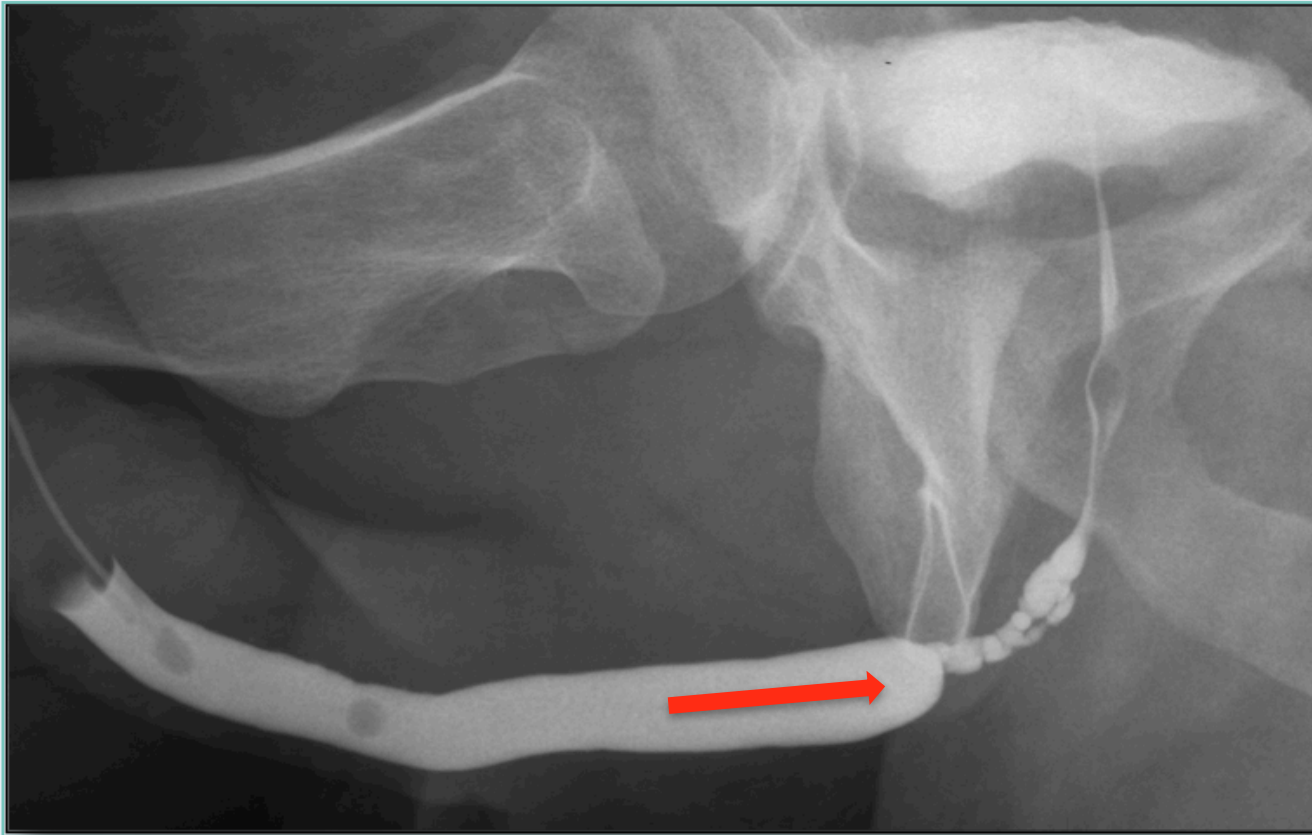
To avoid erectile dysfunction



Dissection and/or urethral transection may cause ED

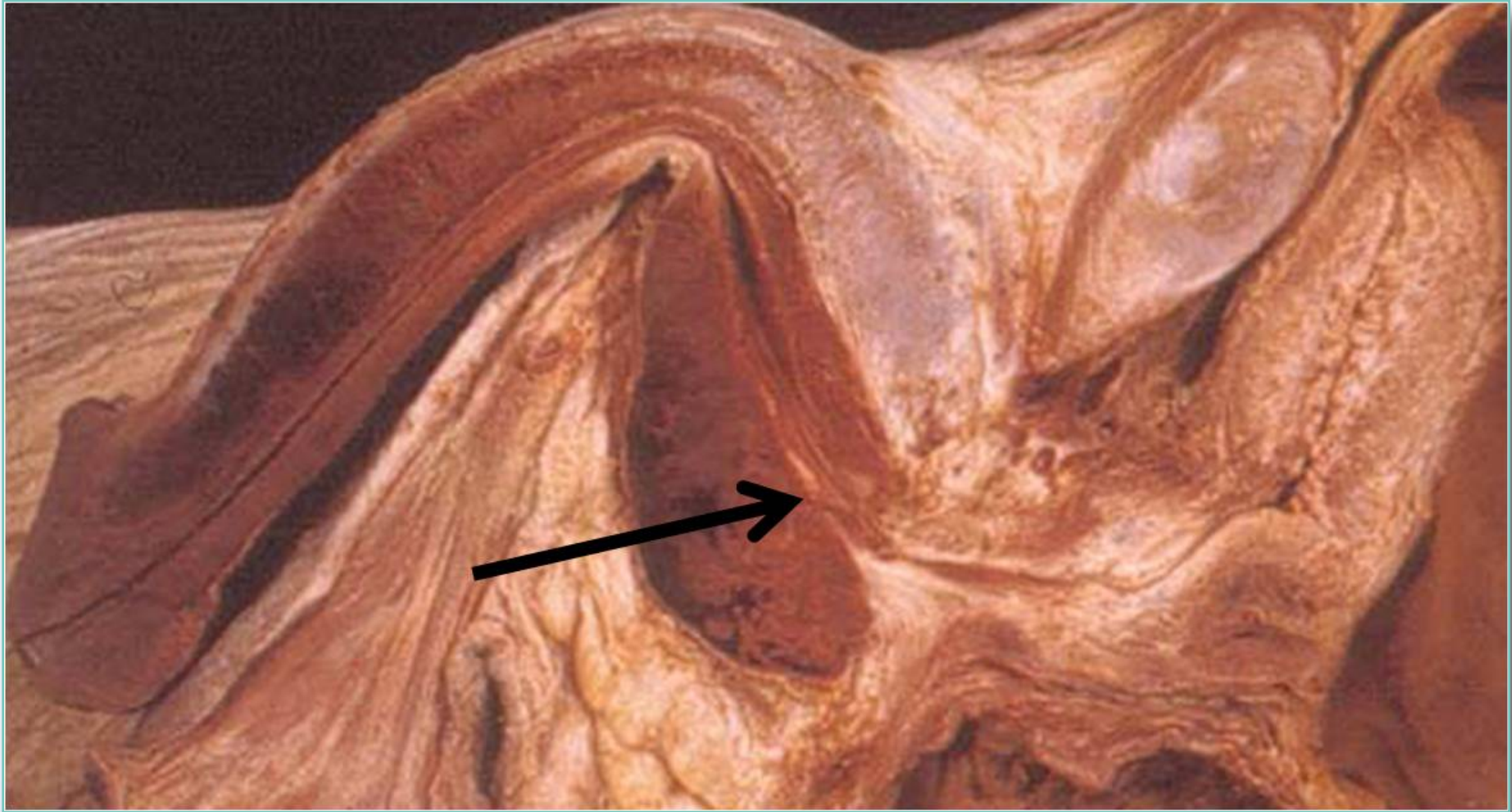


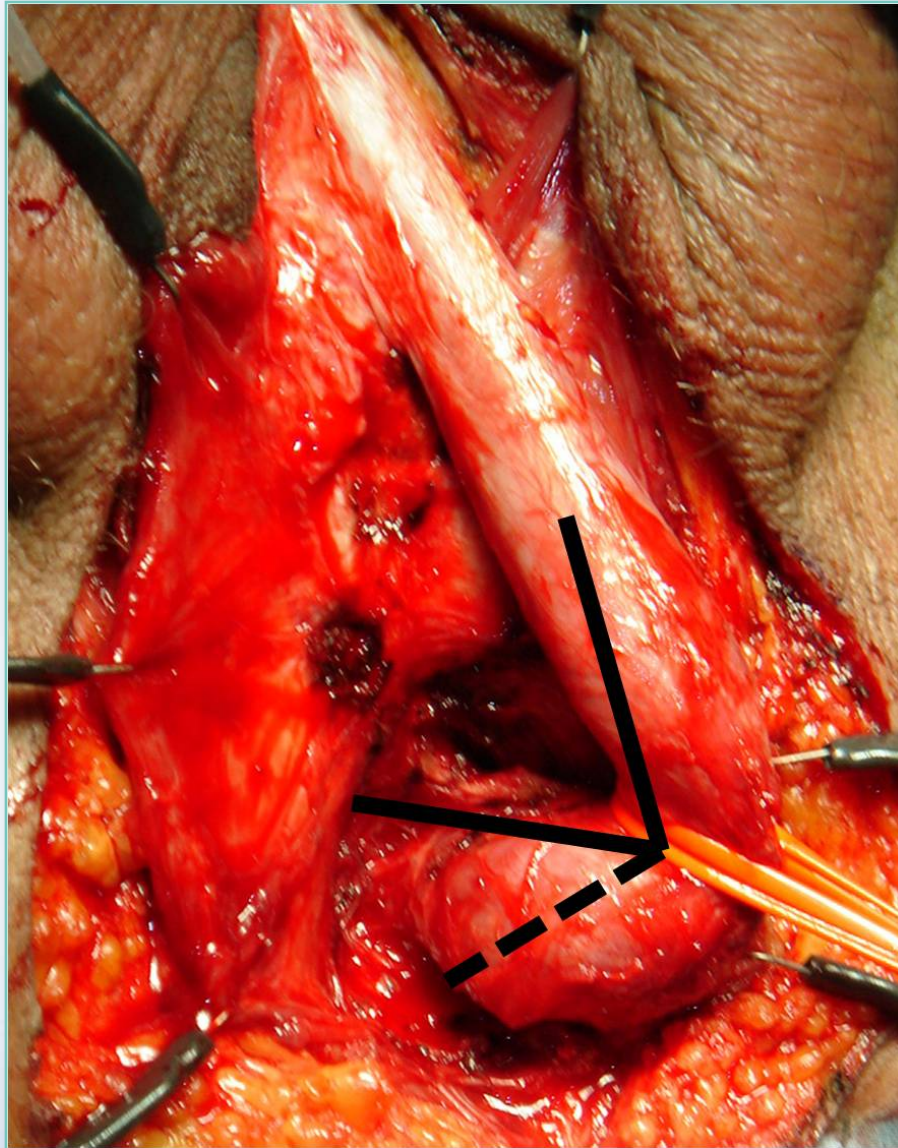
To avoid erectile dysfunction

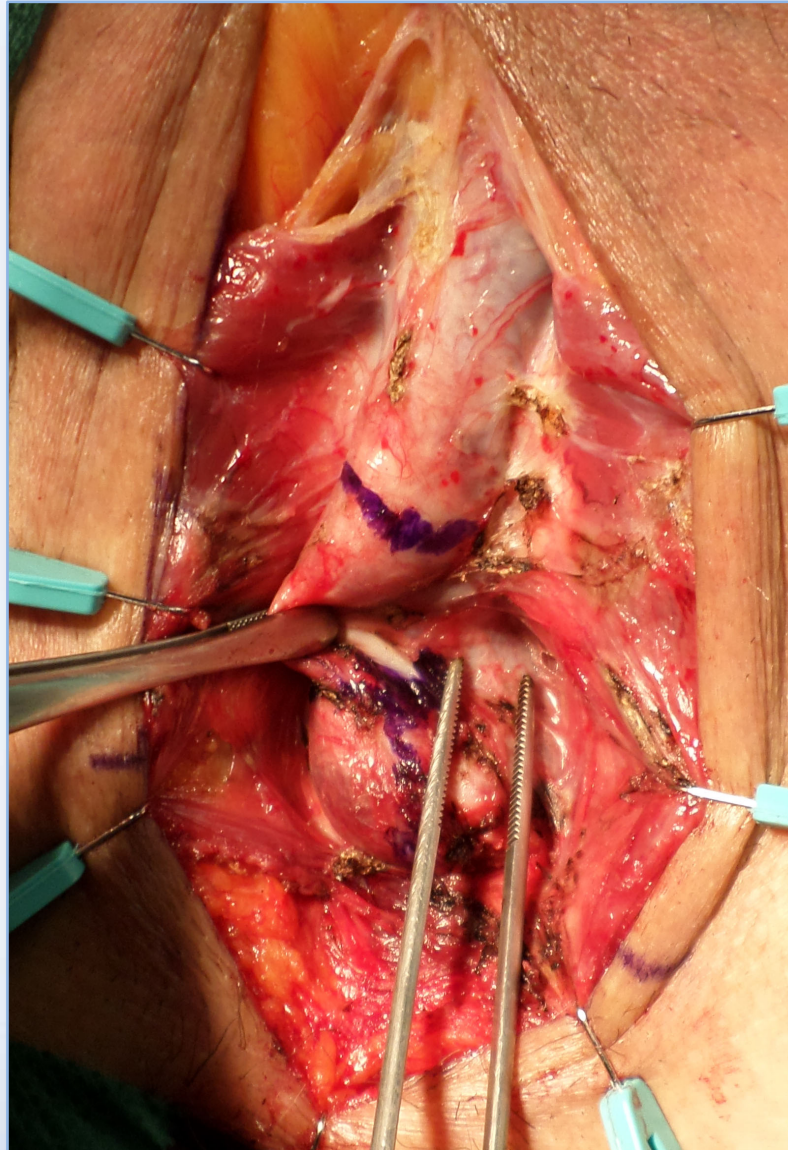


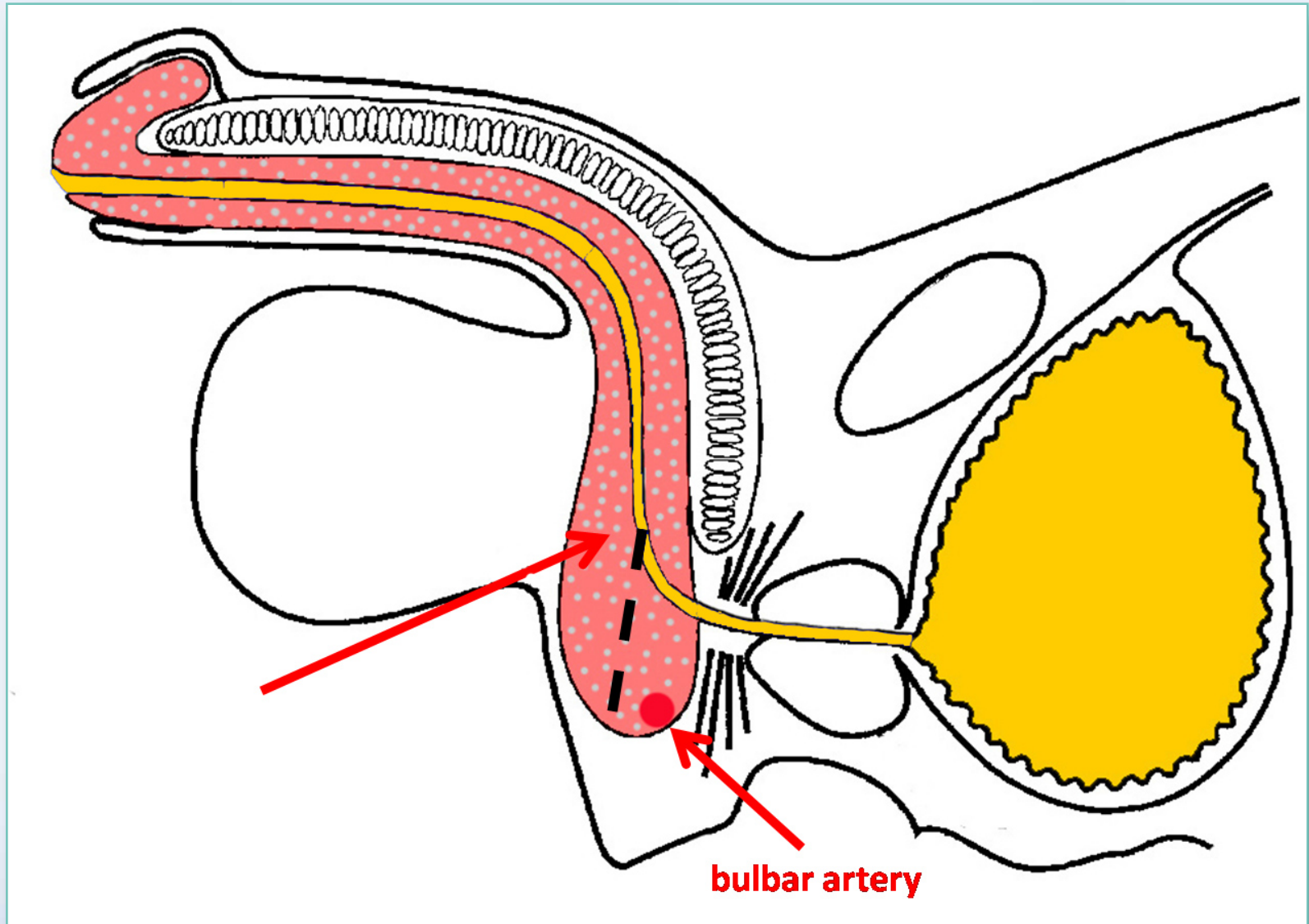
**Work inside the urethra and
not around the urethra**

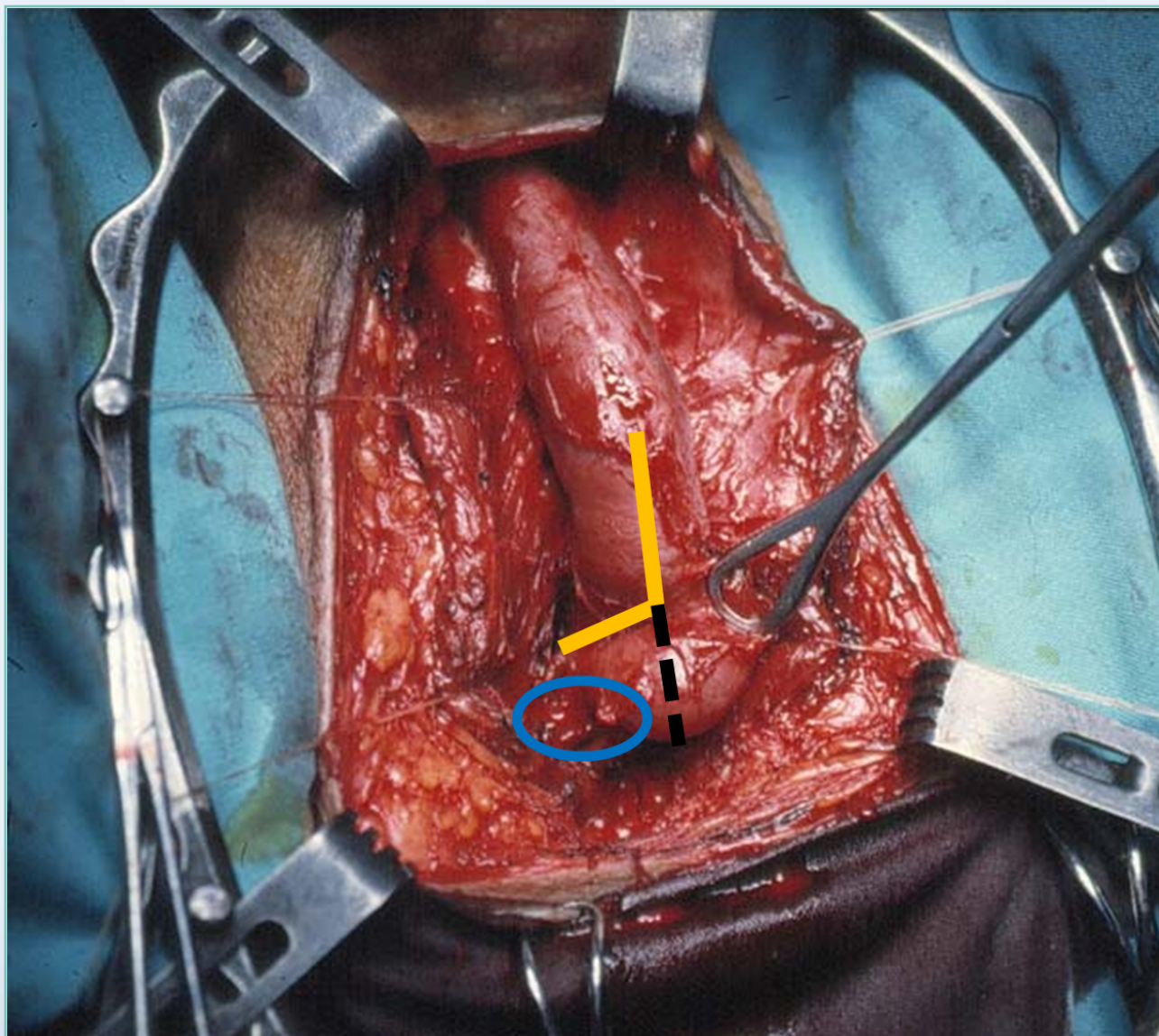


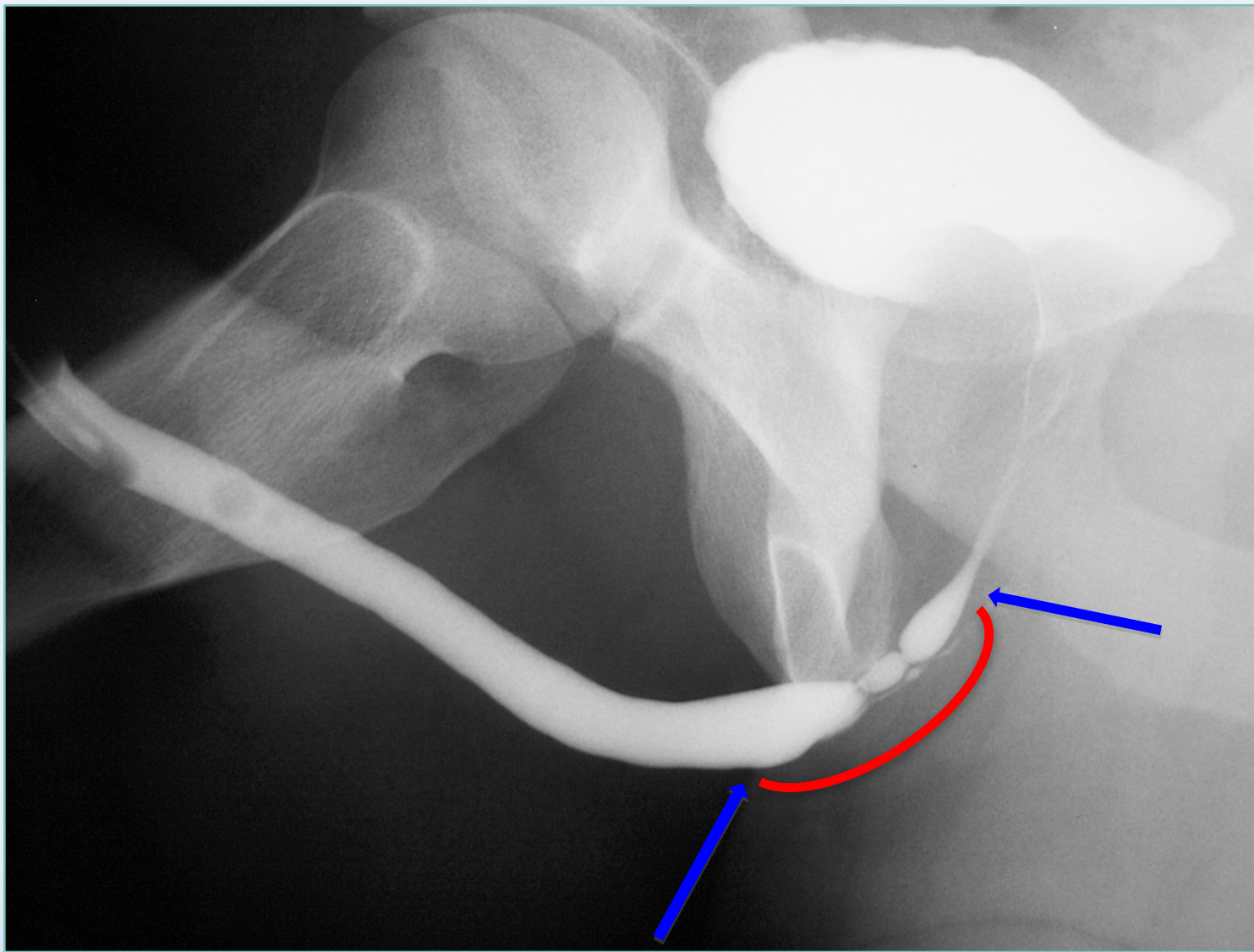


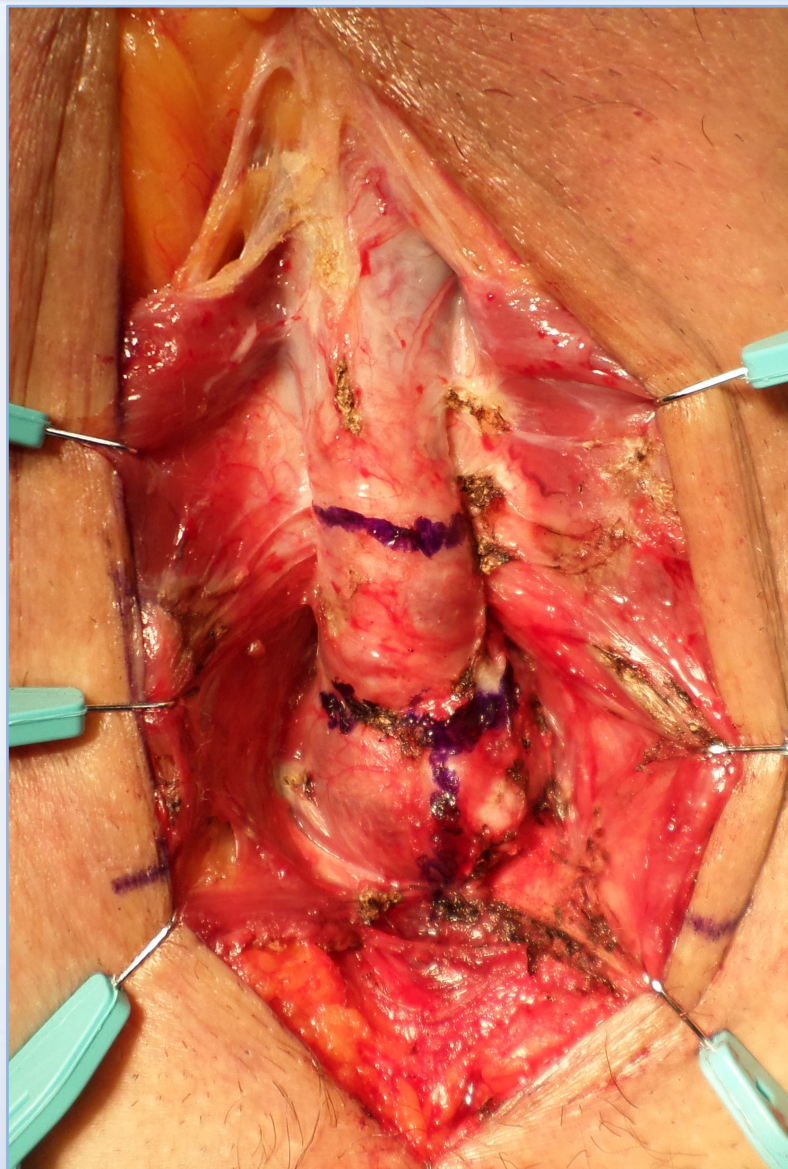


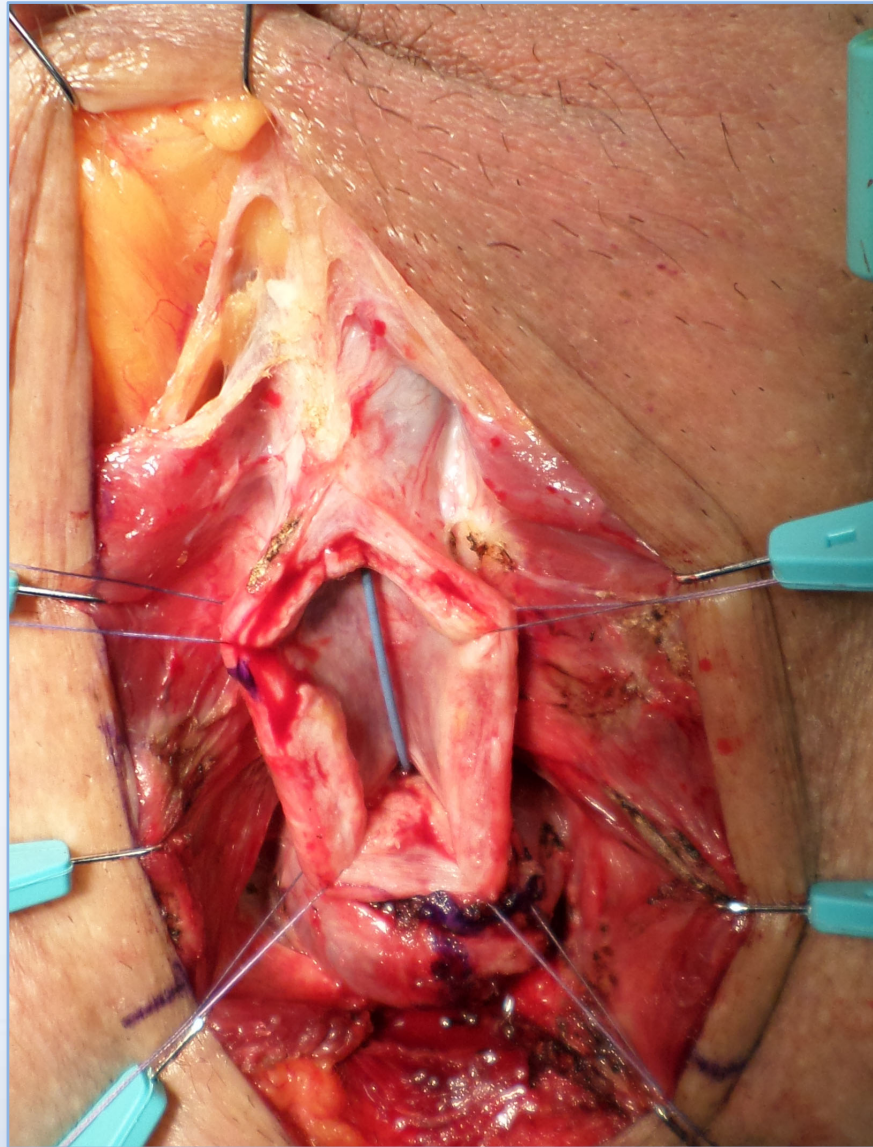


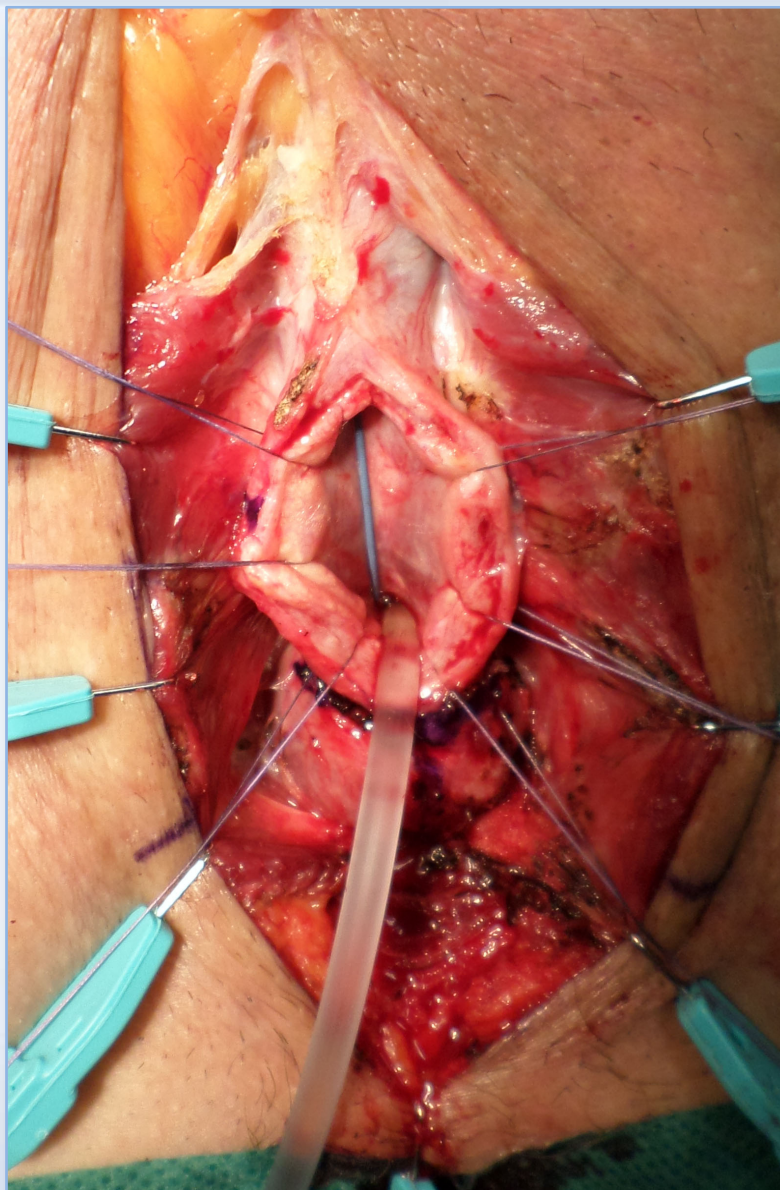


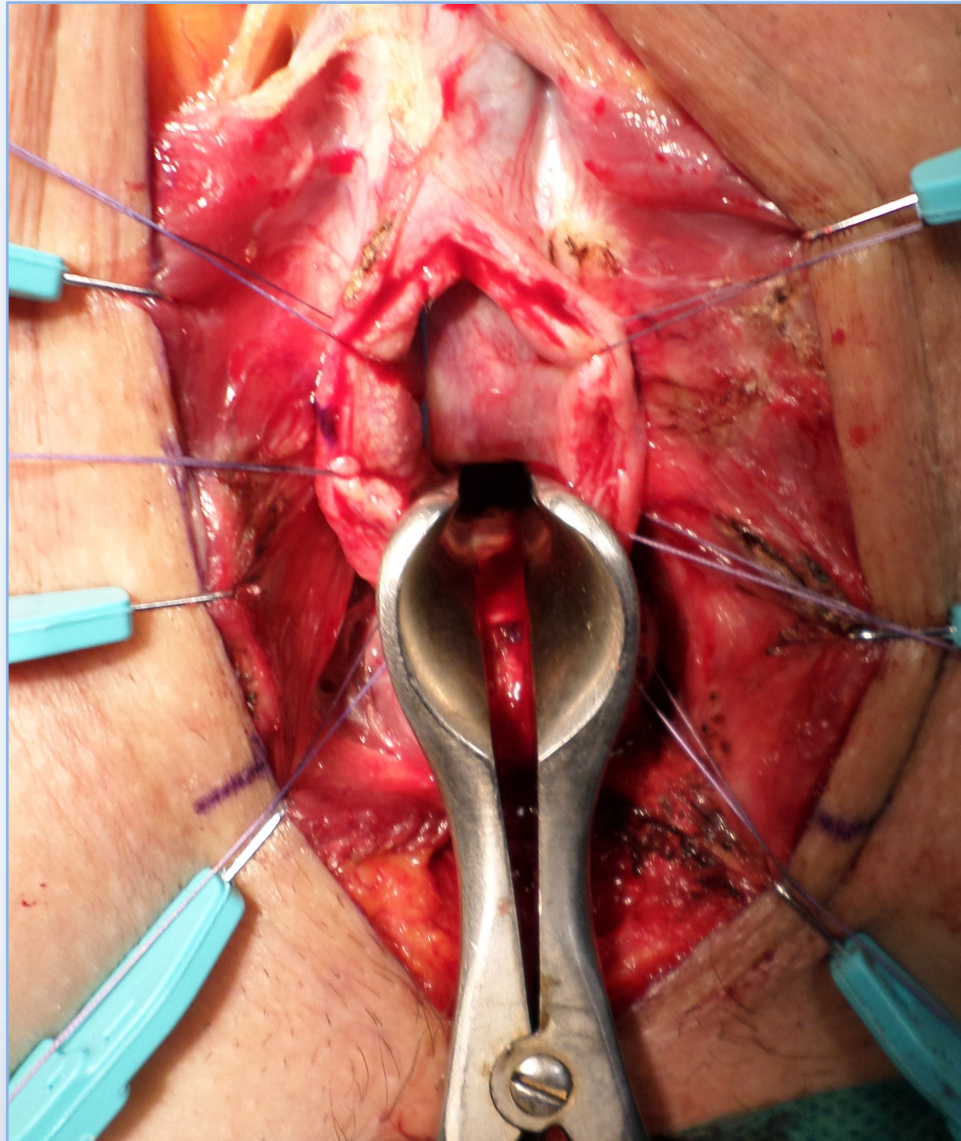


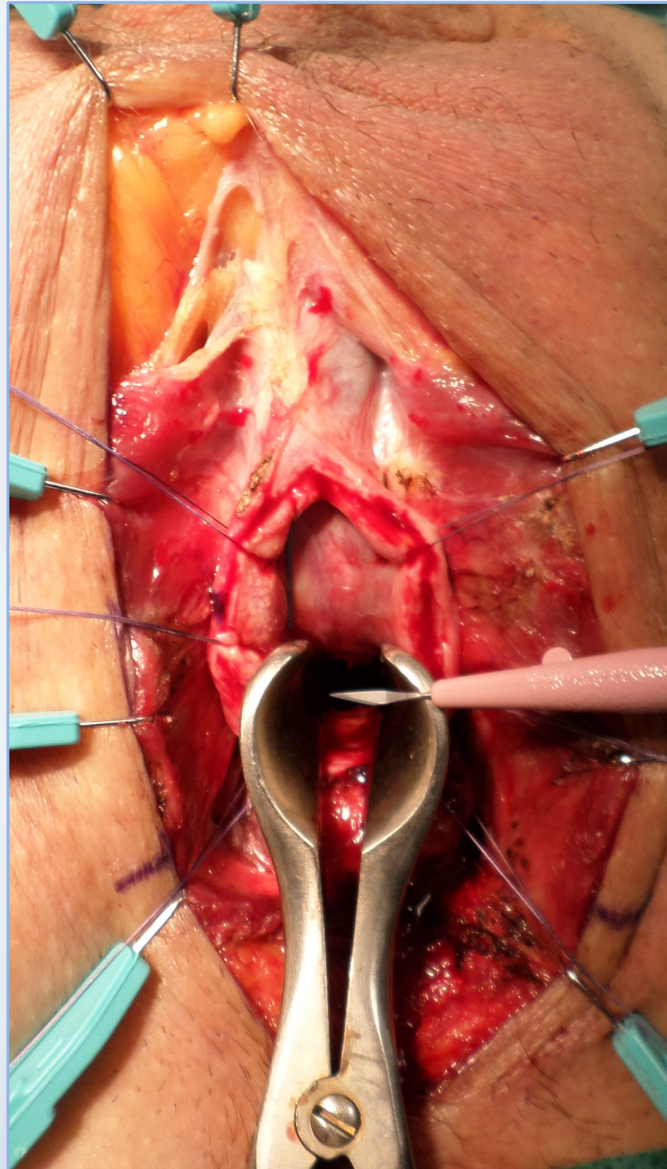


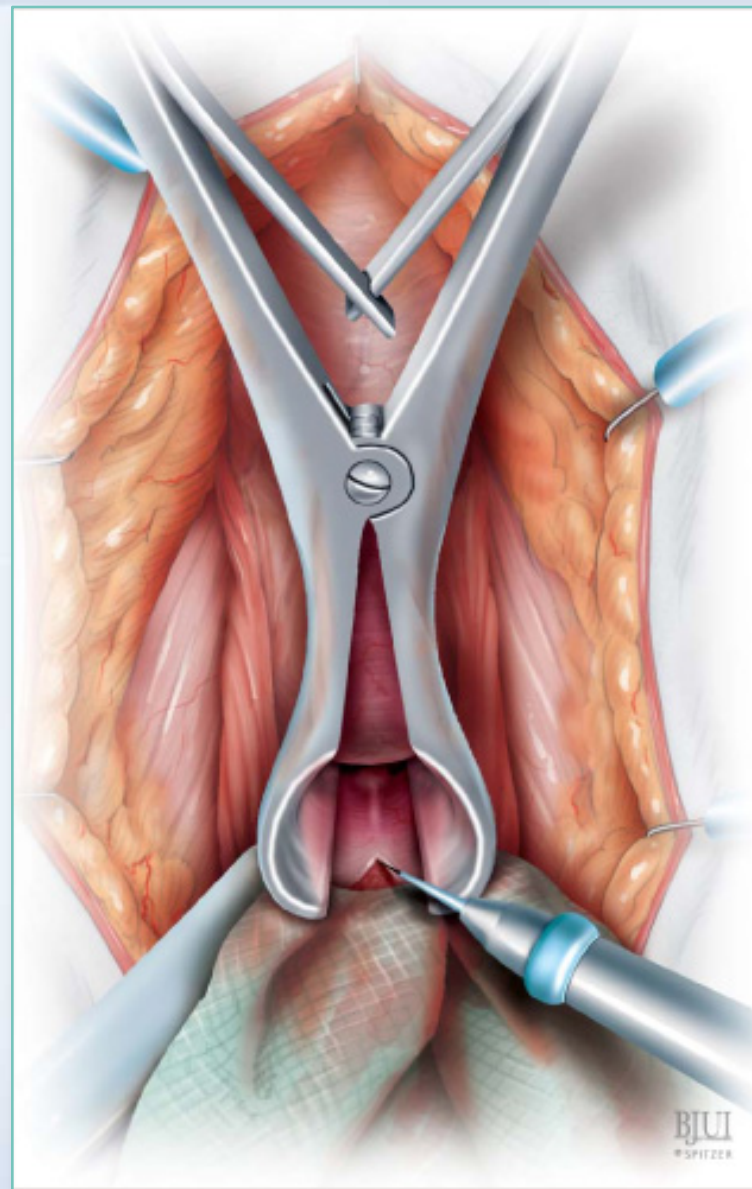
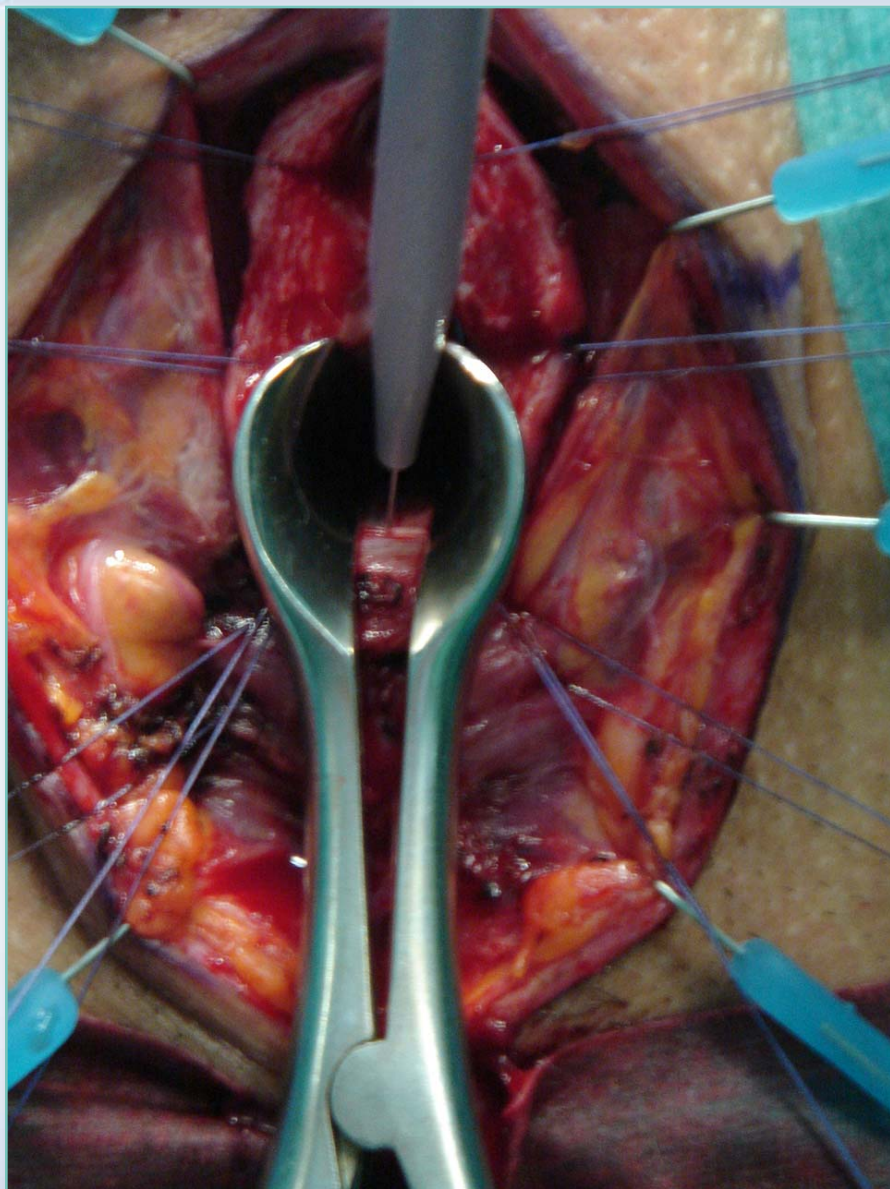






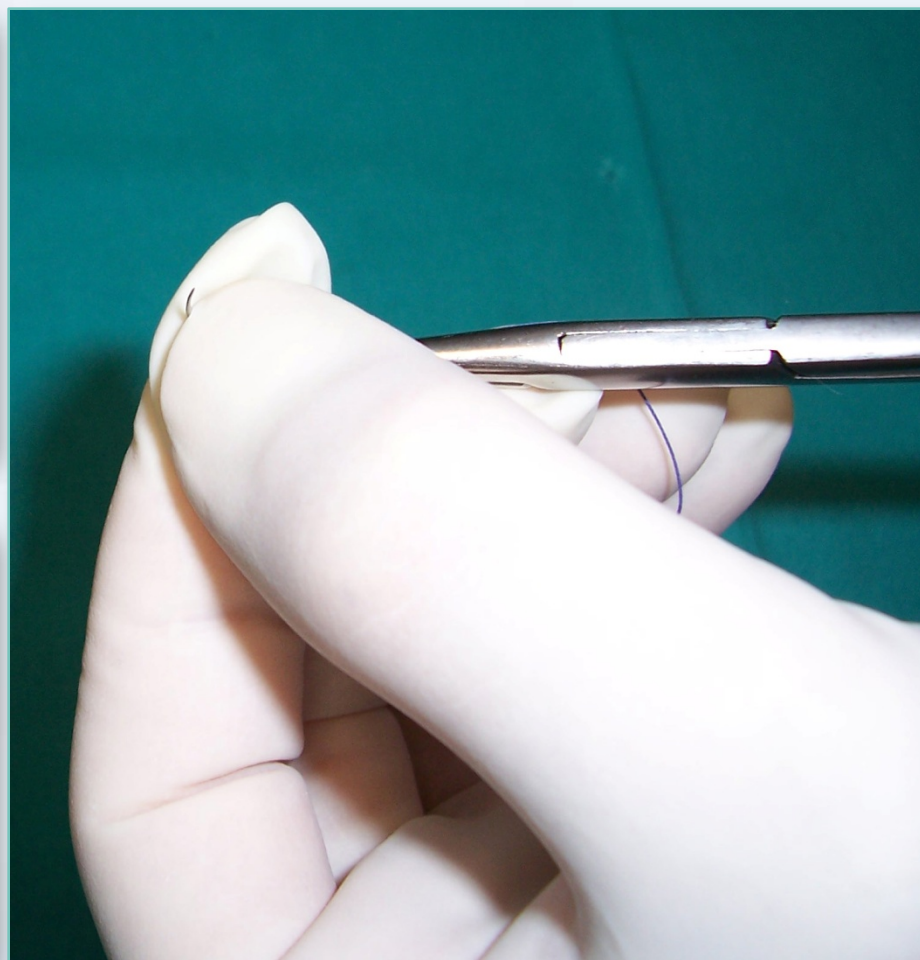
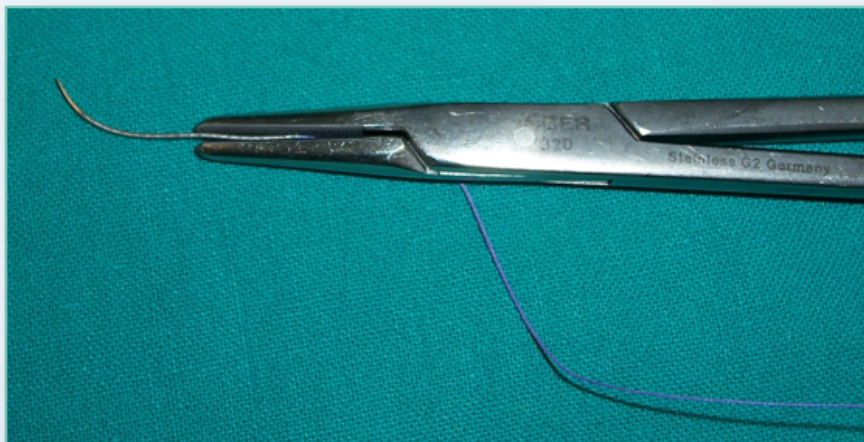


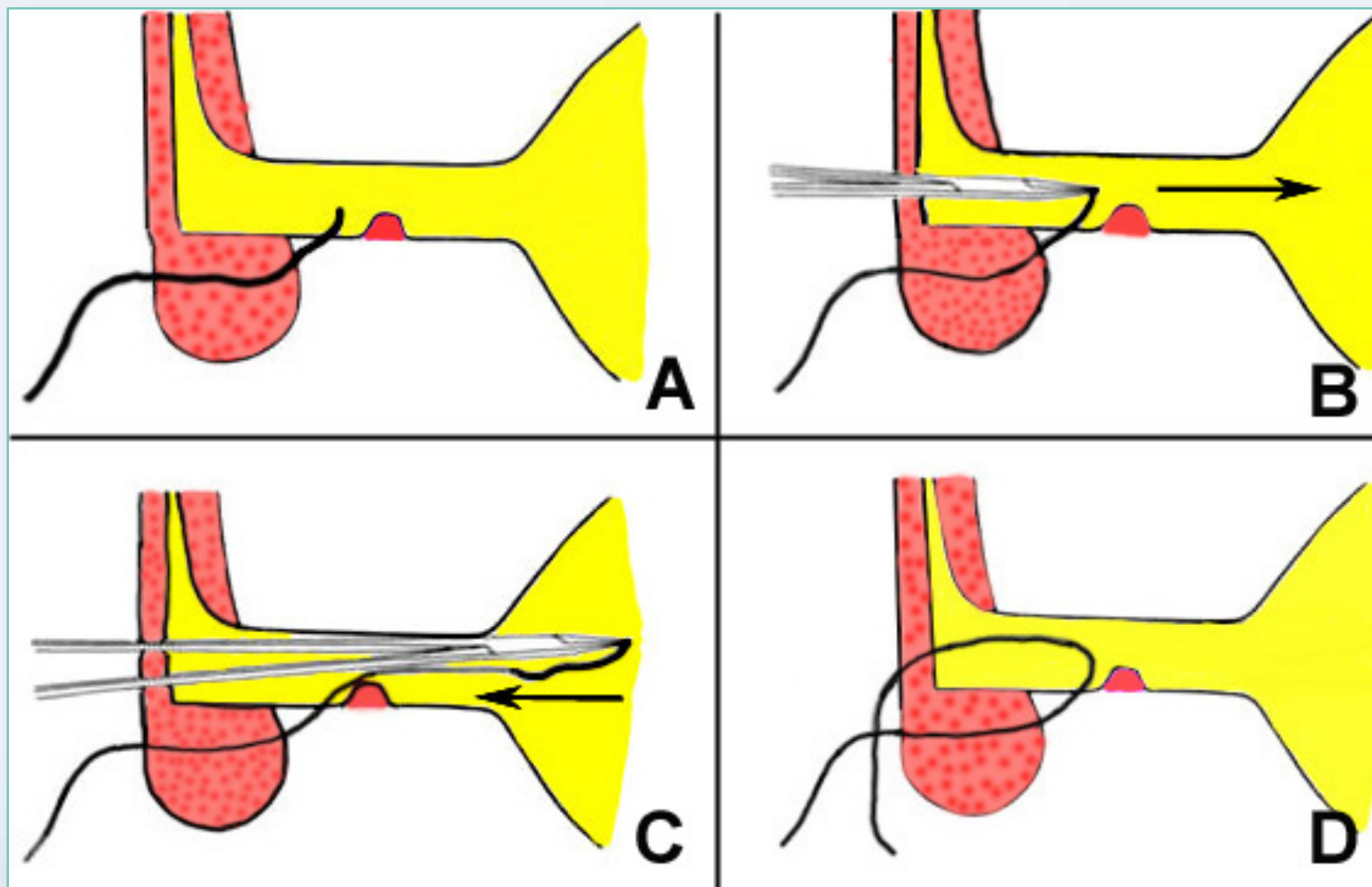


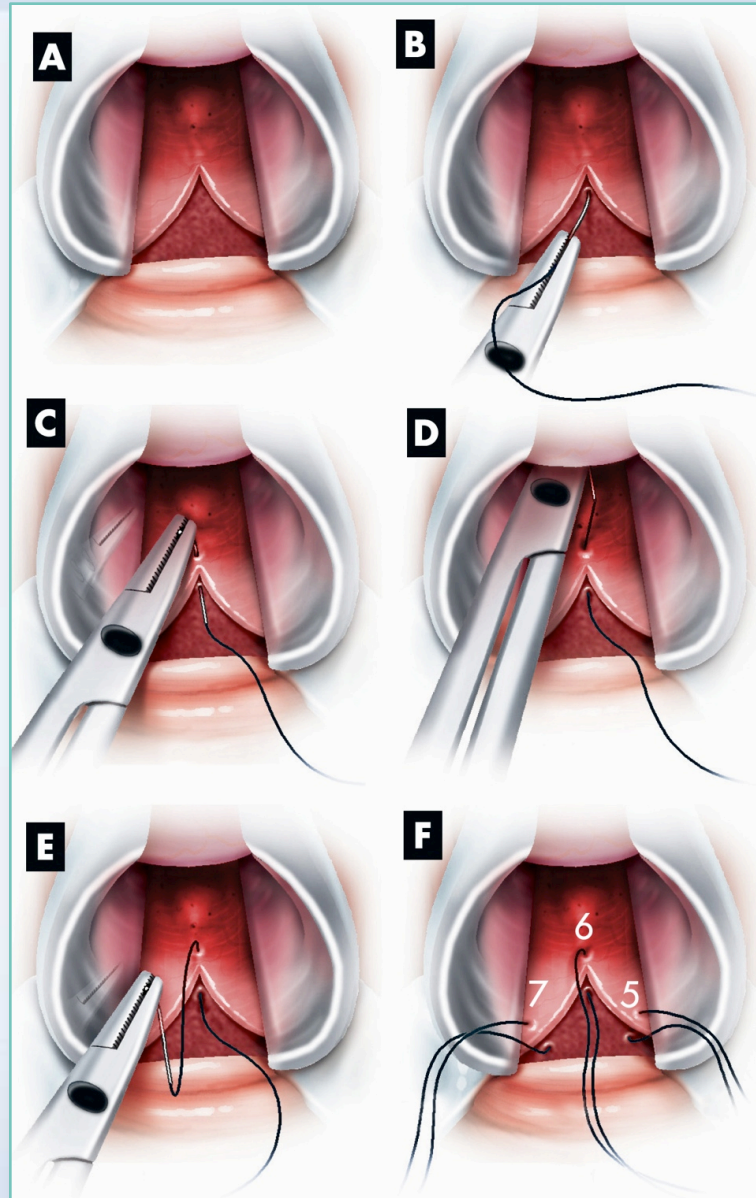


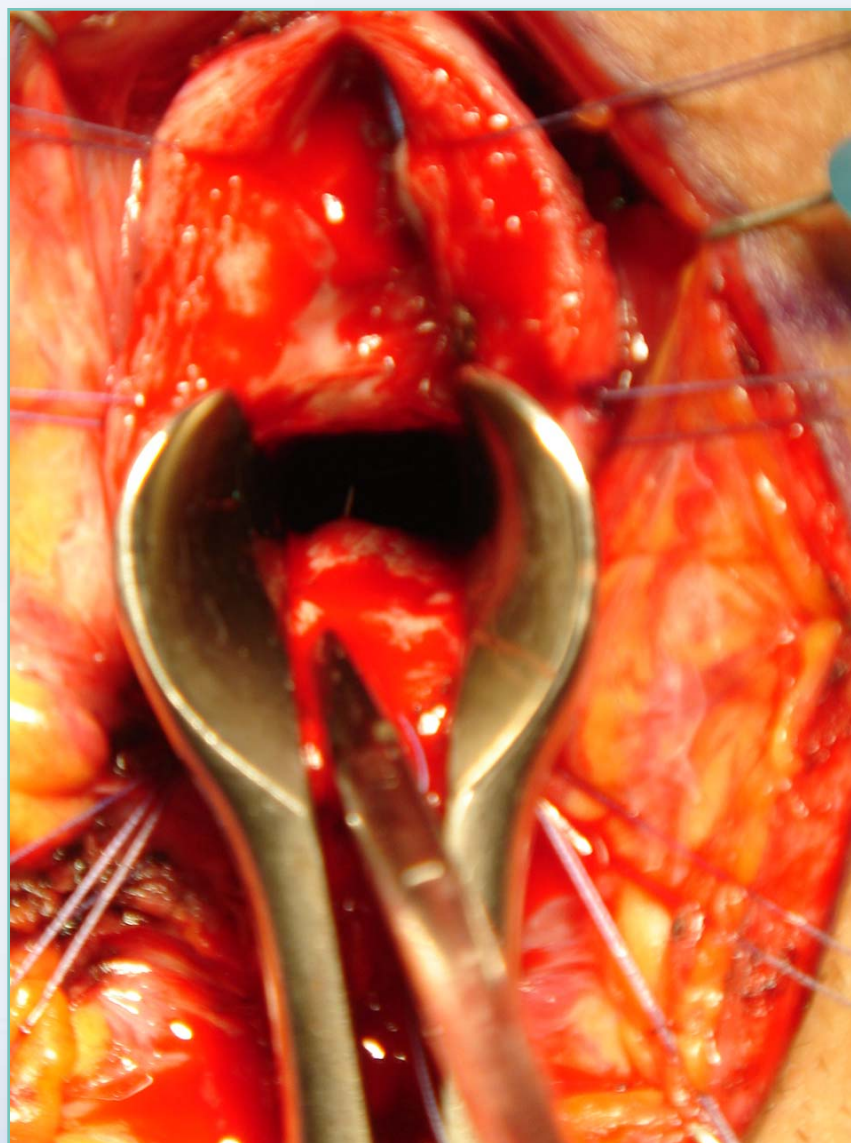
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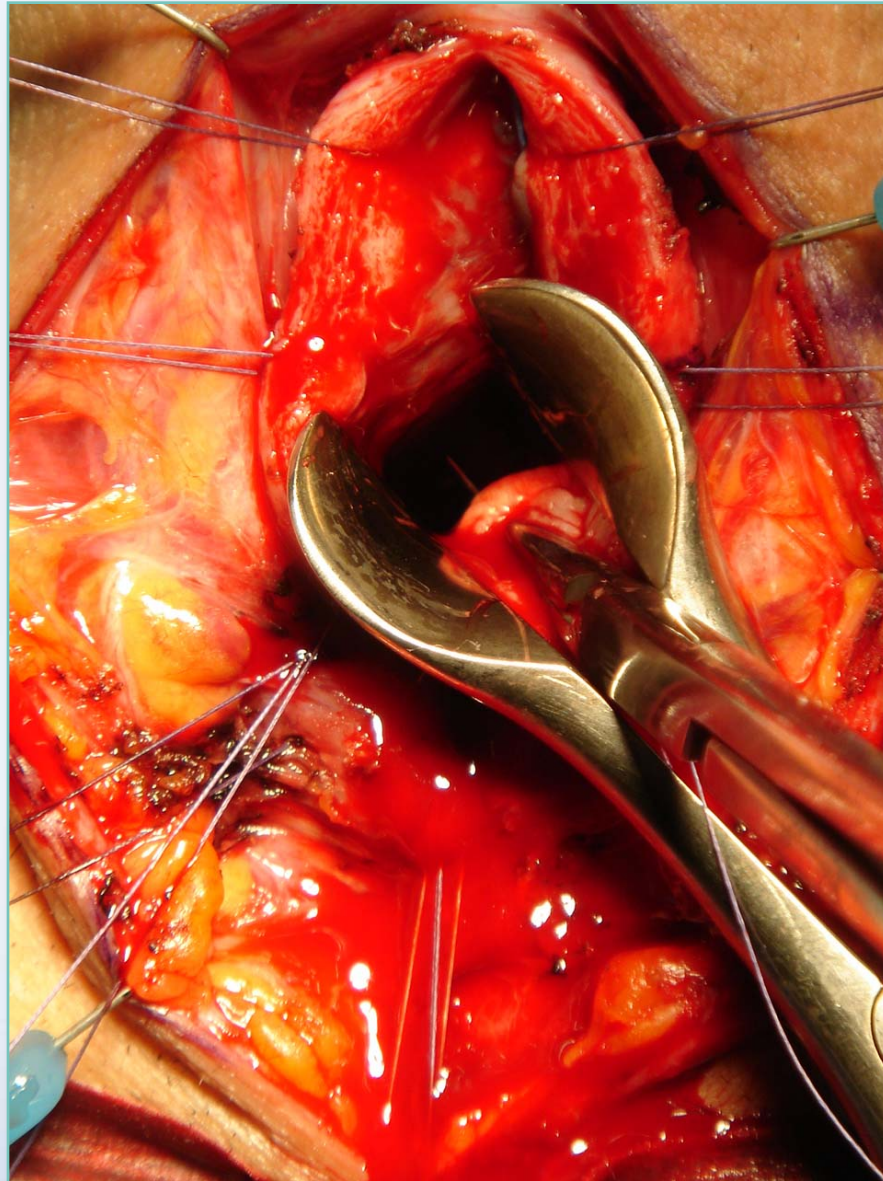
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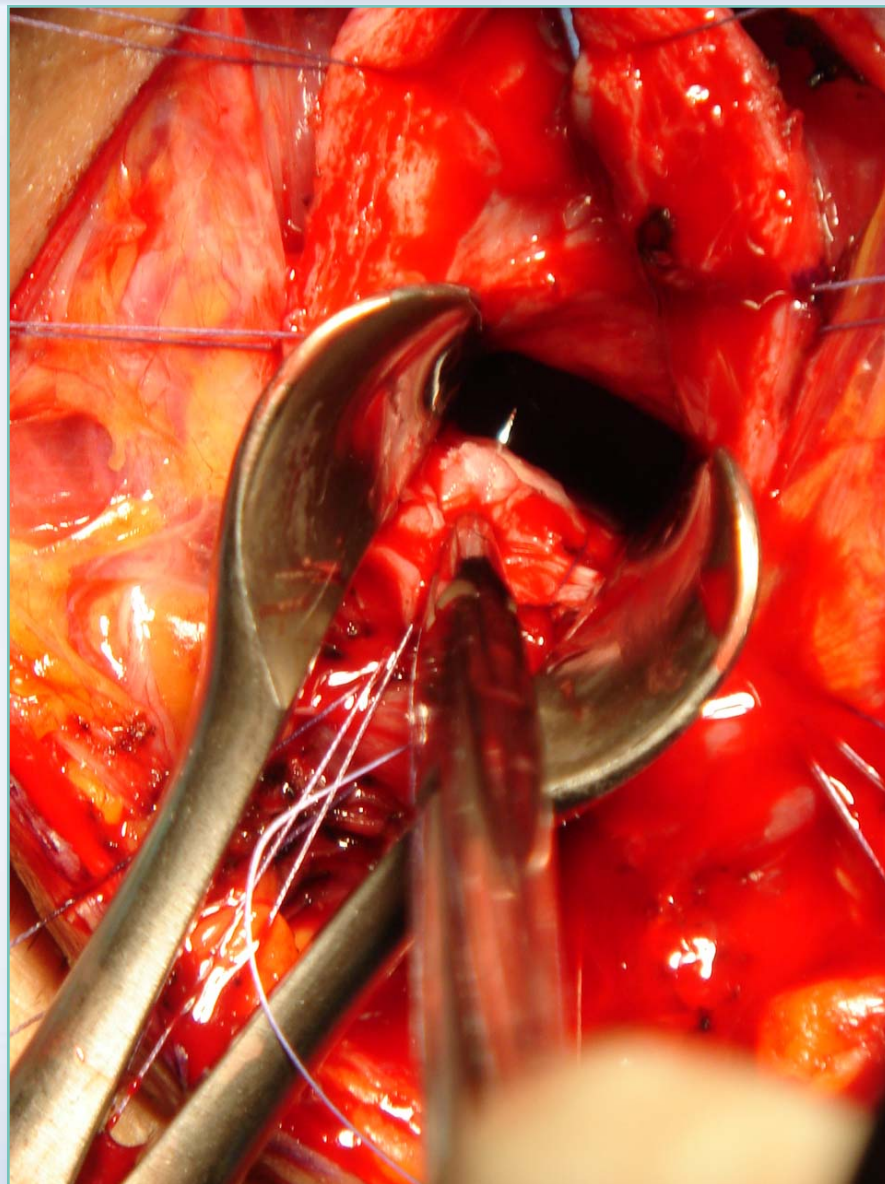


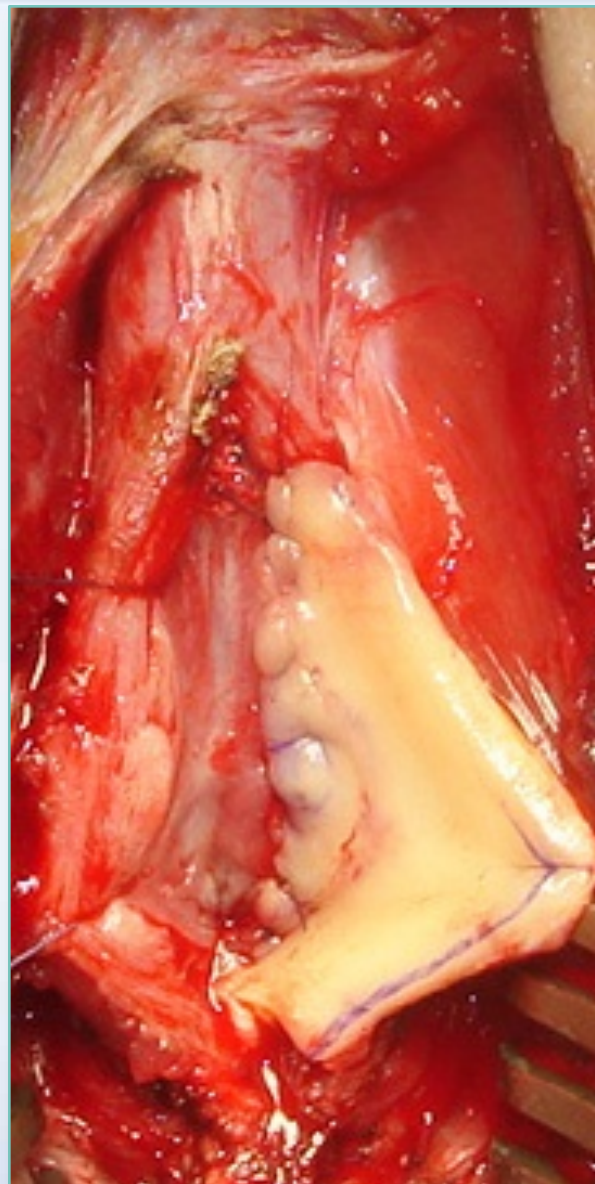
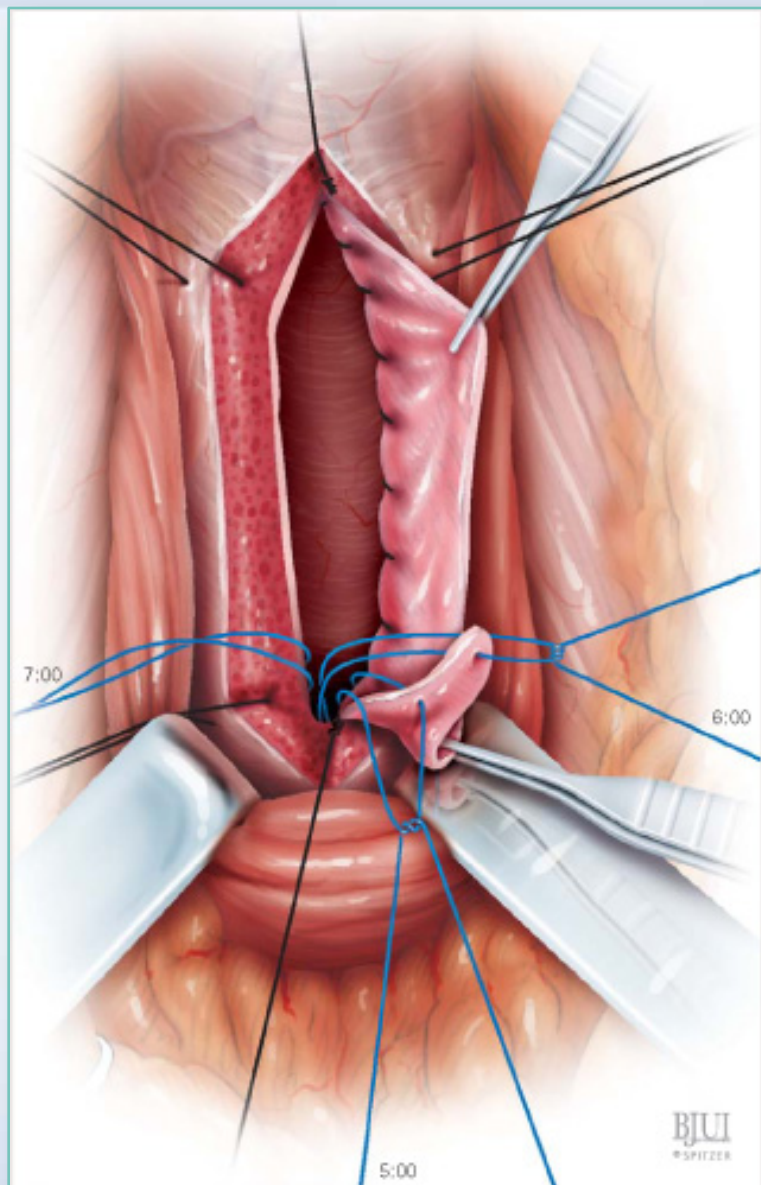


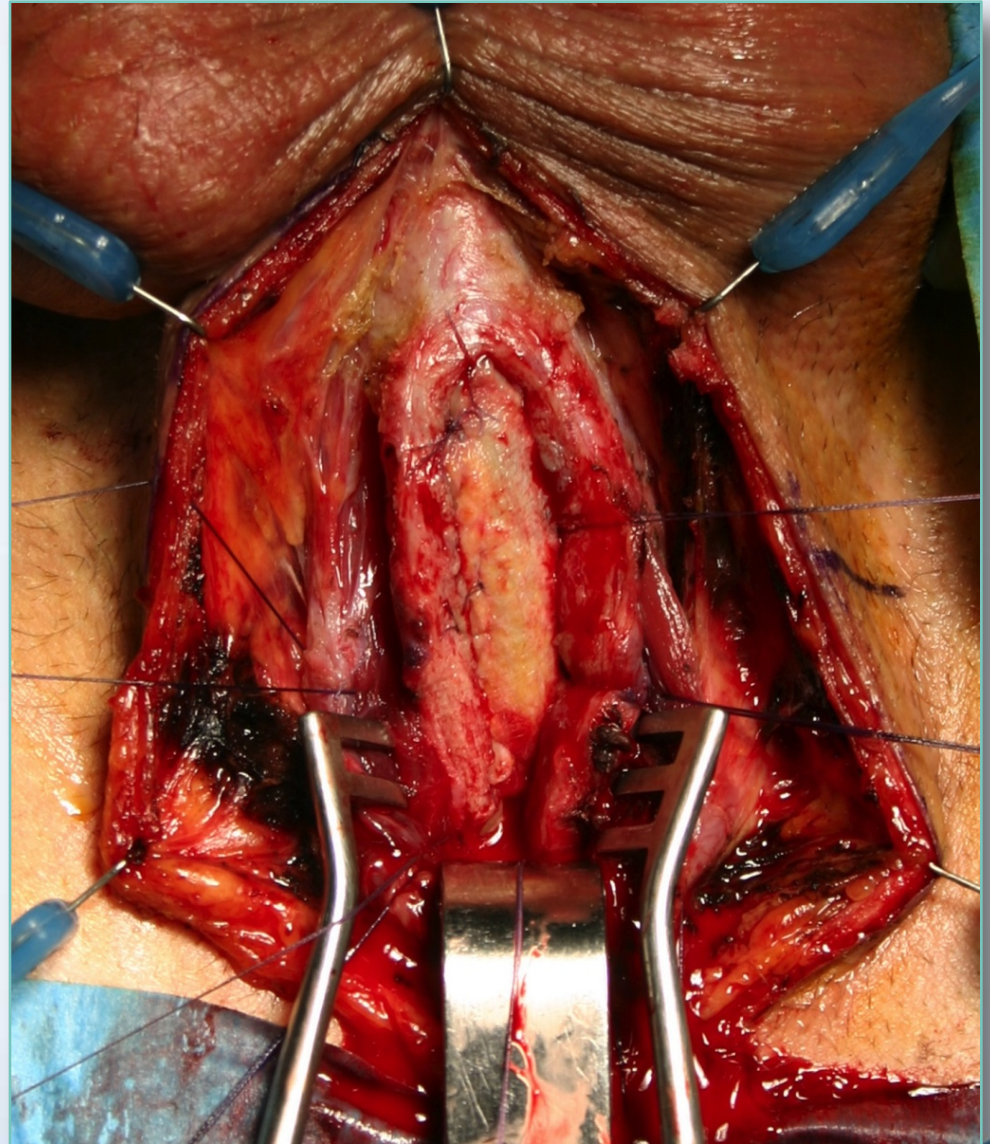
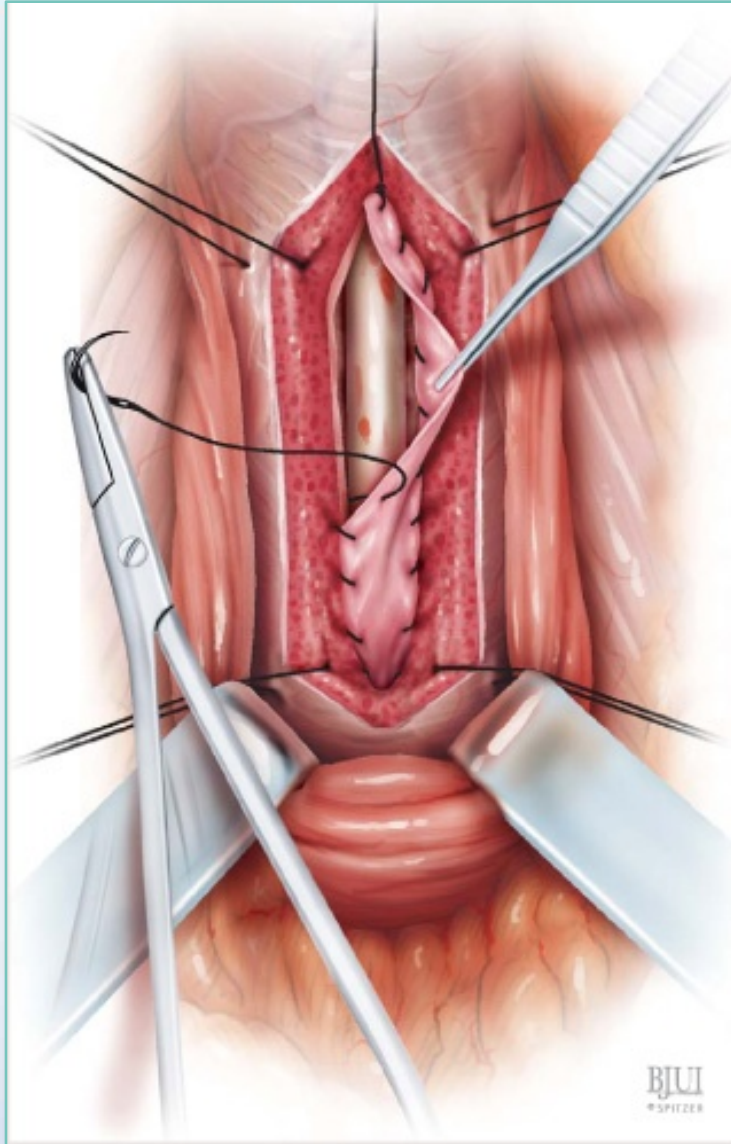


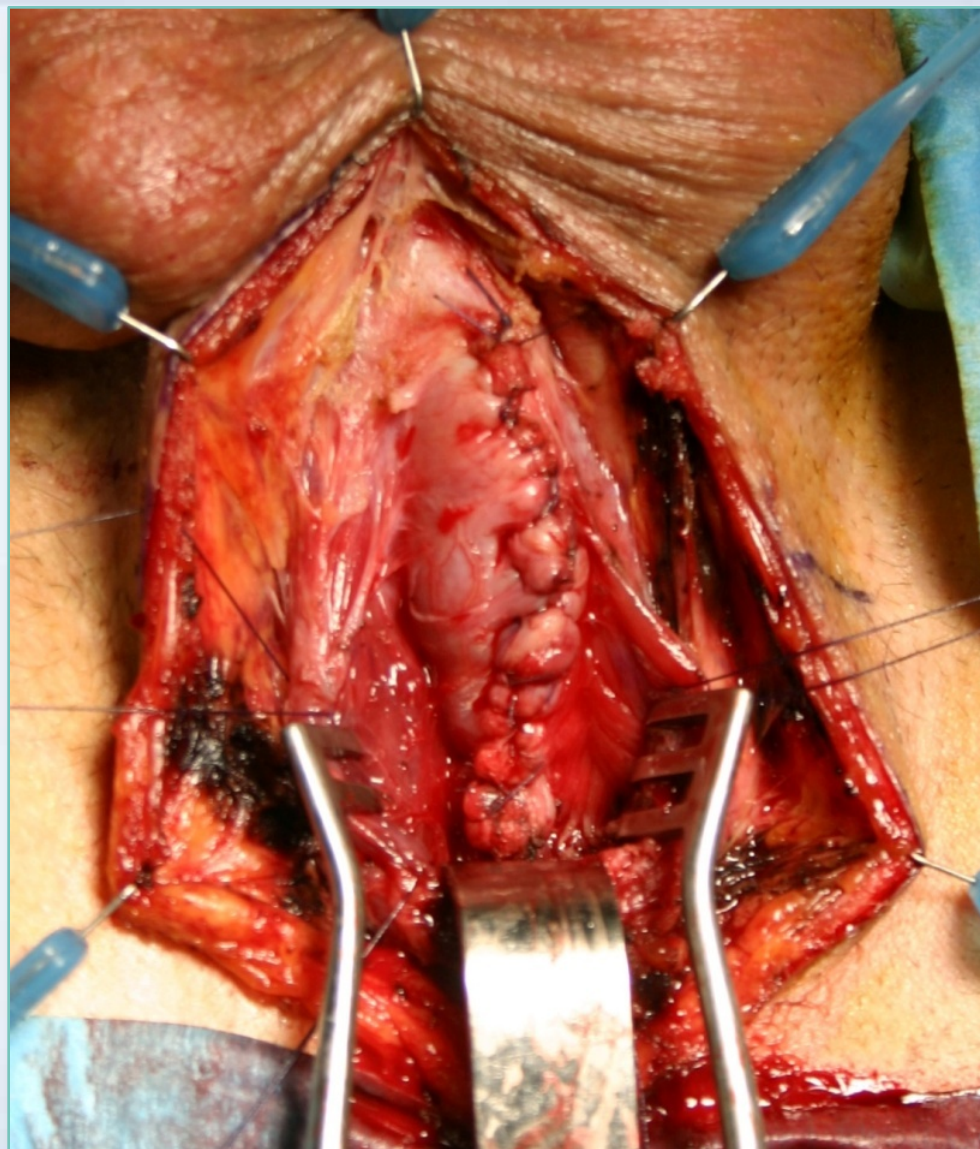
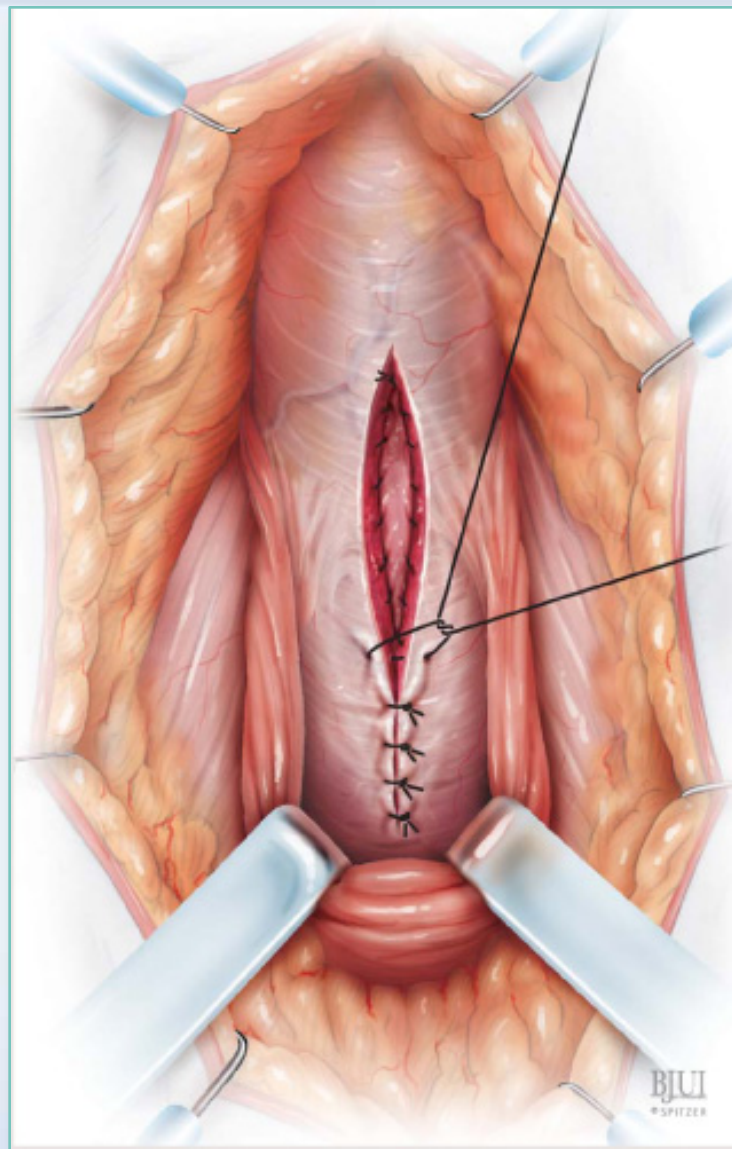








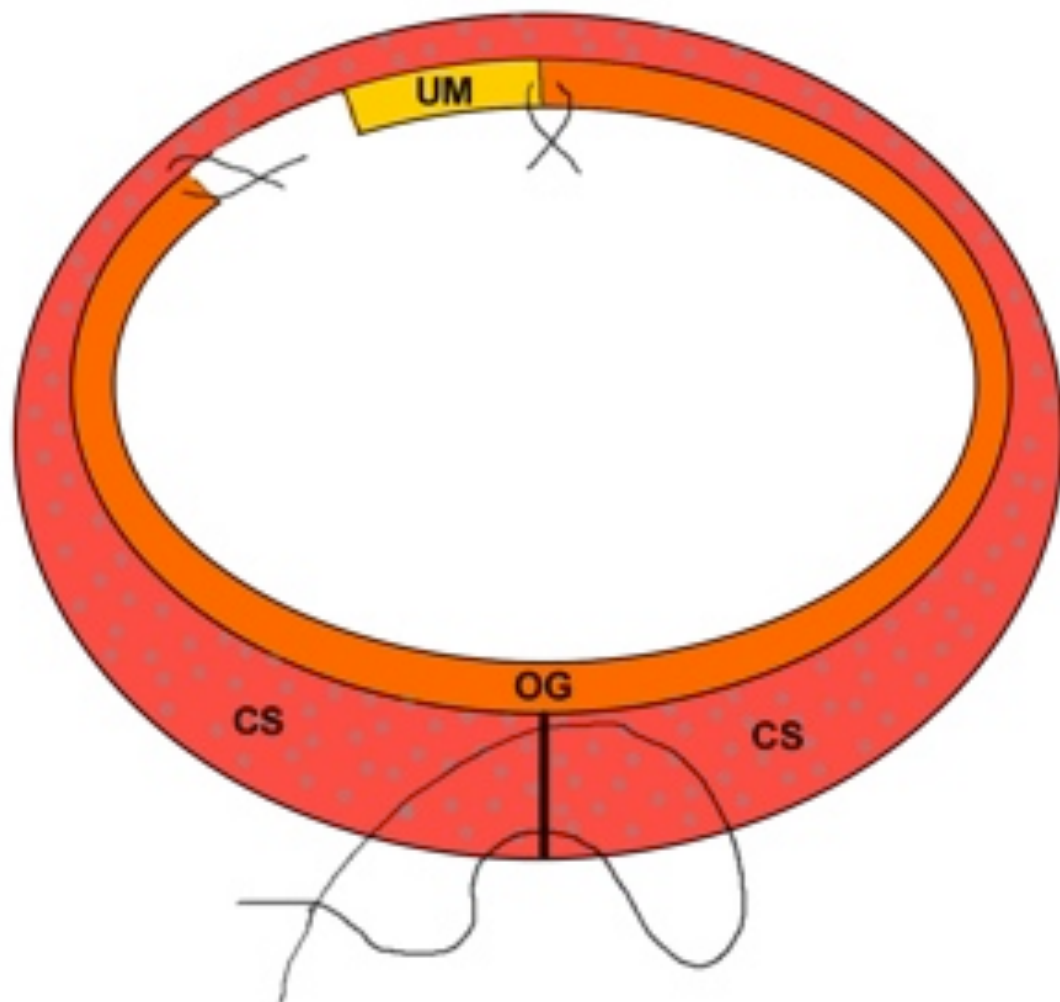
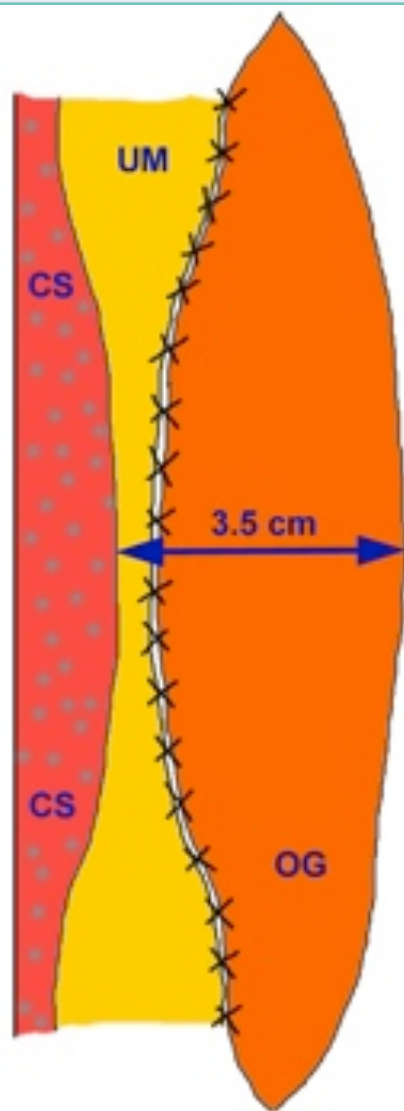


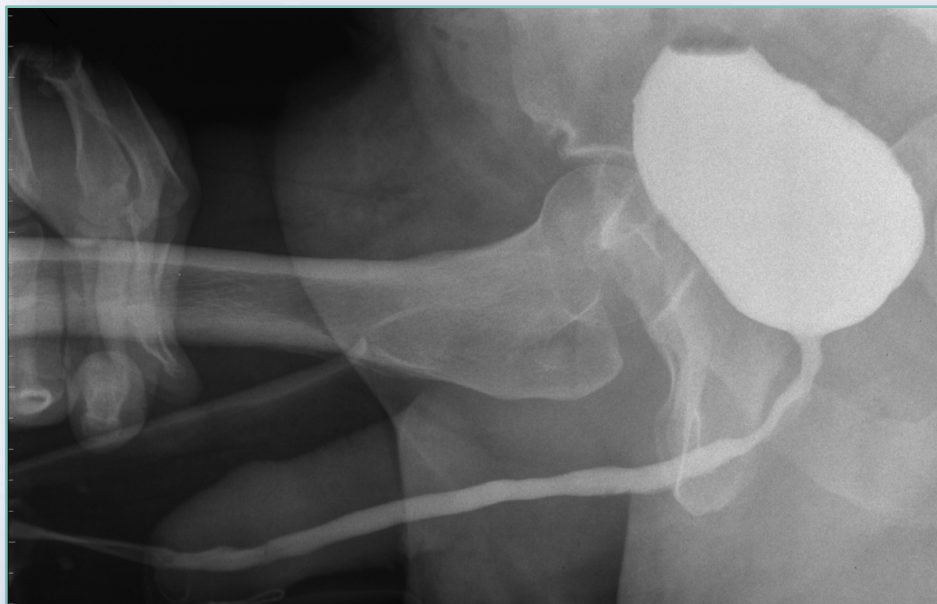




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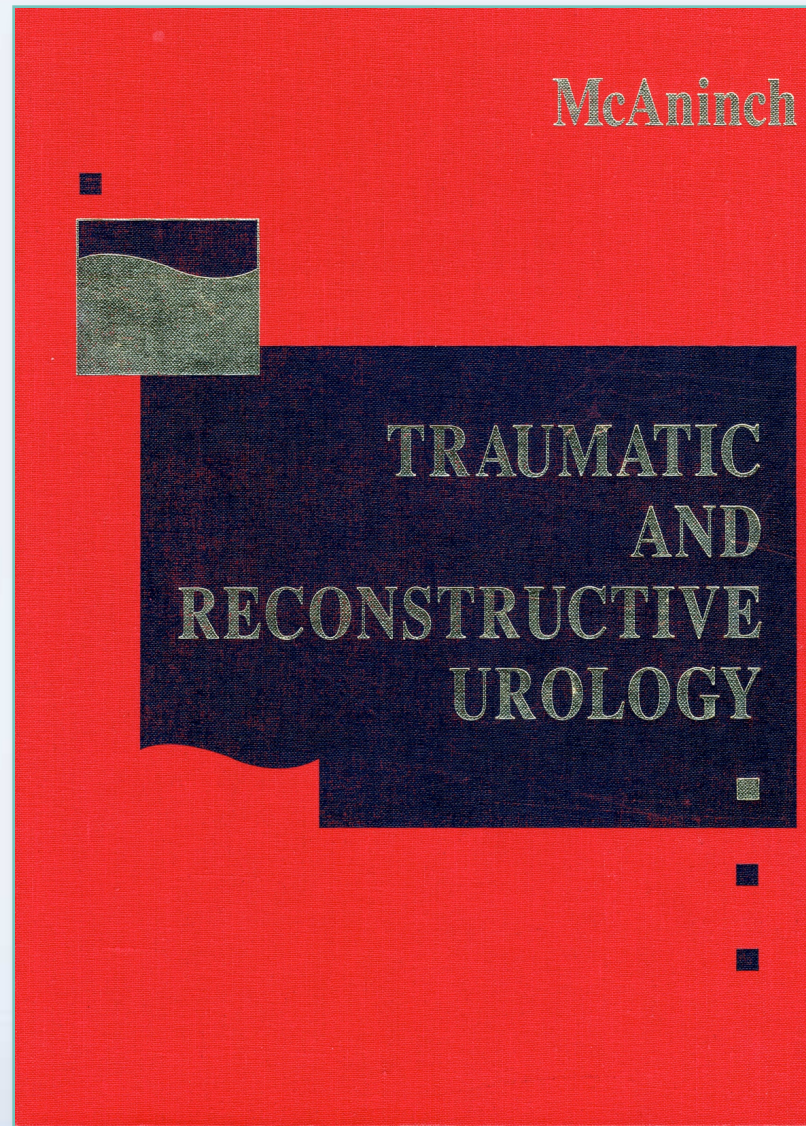
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Table 1. *Penile and bulbar urethral surgery*

Surgery	No. Pts	No. Success (%)	No. Failure (%)	Median Mos Followup (range)
Bulbar urethra:	305	225 (73.8)	80 (26.2)	118 (72–240)
Dorsal skin onlay graft urethroplasty	33	21 (63.6)	12 (36.4)	190 (161–240)
Dorsal oral mucosa onlay graft urethroplasty	81	65 (80.2)	16 (19.8)	111 (72–180)
Lateral oral mucosal onlay graft urethroplasty	6	5 (83.3)	1 (16.7)	160 (158–163)
Ventral oral mucosal onlay graft urethroplasty	130	106 (81.5)	24 (18.5)	103 (72–160)
Circumferential substitution oral mucosal graft urethroplasty	12	7 (58.3)	5 (41.7)	131 (124–138)
Augmented anastomotic repair with dorsal skin graft	10	2 (20)	8 (80)	183 (132–228)
Augmented anastomotic repair with dorsal oral mucosal graft	24	18 (75)	6 (25)	113 (83–140)
Augmented anastomotic repair with ventral oral mucosal graft	9	1 (11.1)	8 (88.9)	107 (76–140)
Penile urethra (1-stage urethroplasty):	54	40 (74.1)	14 (25.9)	117 (75–206)
With oral mucosal graft	20	17 (85)	3 (15)	125 (75–150)
With penile skin flap	13	10 (76.9)	3 (23.1)	99 (79–196)
With skin graft	21	13 (61.9)	8 (38.1)	115 (76–206)

Eur Urol 2014; 192: 808-813





1996



CHAPTER

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Substitution Urethroplasty and the Pedicled Island Penile Skin Procedure

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Mr. Richard Turner-Warwick



Observations on Hemostatic and Hemorrhagic Anesthesiologic Procedures

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All operations on the anterior urethra naturally involve the spongy tissue so that a basic requirement of urethral surgery is the avoidance of erections or erectile tumescence; this is particularly important for operative procedures that require a definitive spongiosoplasty. It is, therefore, somewhat remarkable that one of the commonest anesthetic procedures offered for urologic operations is an epidural block—the tumescence and partial erection that this commonly creates may reassure the anesthesiologist that the anesthesia is progressing satisfactorily—but is not helpful to the urologist.

Urologists commonly complain about unwanted erections, but many anesthesiologists have never been asked to prevent them—and some do not know how to prevent them effectively. It is important to appreciate that a positively diminished erectile tissue blood supply and an induced systemic hypotension are quite different hemodynamic features that may or may not be coincident during anesthesia. In general, a pharmacologic ganglion blockade sufficient to cause dilatation of the pupils induces a specific reduction in the vascular circulation of the erectile tissue and enables one to “look into the interstices” of the spongy tissue after sponging (instead of a constant welling up) before it significantly reduces the systolic blood pressure. A secret of a comfortable surgical operating field is induced bradycardia.²¹

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“...epidural block is not helpful for the urologist”.





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Impossibile apprendere derivazione V

29-gen 12:36

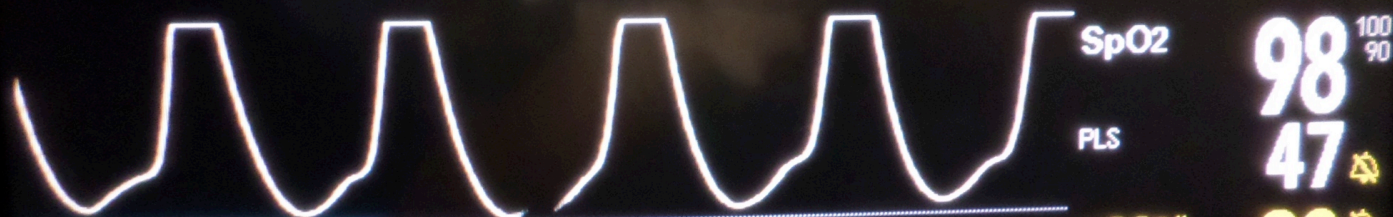


PM OFF

Filtro ESU

Adulto

1 mV



01:01:22

Premere Codice per arrest.

etCO2* 29

RRc* 10 iCO2* 0

NBP 76 160 90
41 110 40
52 12:31 0 10 min

SEV 2.6
et 2.4

N2O 0

gsk



Ultiva[®] 2 mg

**Polvere per concentrato per
soluzione iniettabile/infusione**

Remifentanyl




USO ENDOVENOSO

**2 mg polvere liofilizzata in flaconcini da 5 ml
in confezione da 5 flaconcini**



Conclusions

Sexual dysfunction may occur after open urethroplasty.



Knowledge of anatomy and physiology and adequate surgical strategies as well, may avoid it.





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