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**CORSO  
DI CHIRURGIA  
PELVICA  
ONCOLOGICA  
MININVASIVA:  
UP TO DATE**

**17 - 18 GENNAIO 2019**

**POTENZA**

Azienda Ospedaliera San Carlo  
U.O. UROLOGIA

Palazzo di Vetro, Primo Piano - Sala A  
Via Potito Petrone, 85100 Potenza PZ

**Anastomosi  
vescico-uretrale**

**Dott. S. Lioi**



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AZIENDA OSPEDALIERA - POTENZA

# TRIFECTA

**1- Undetectable  
PSA**

**2- Potency**

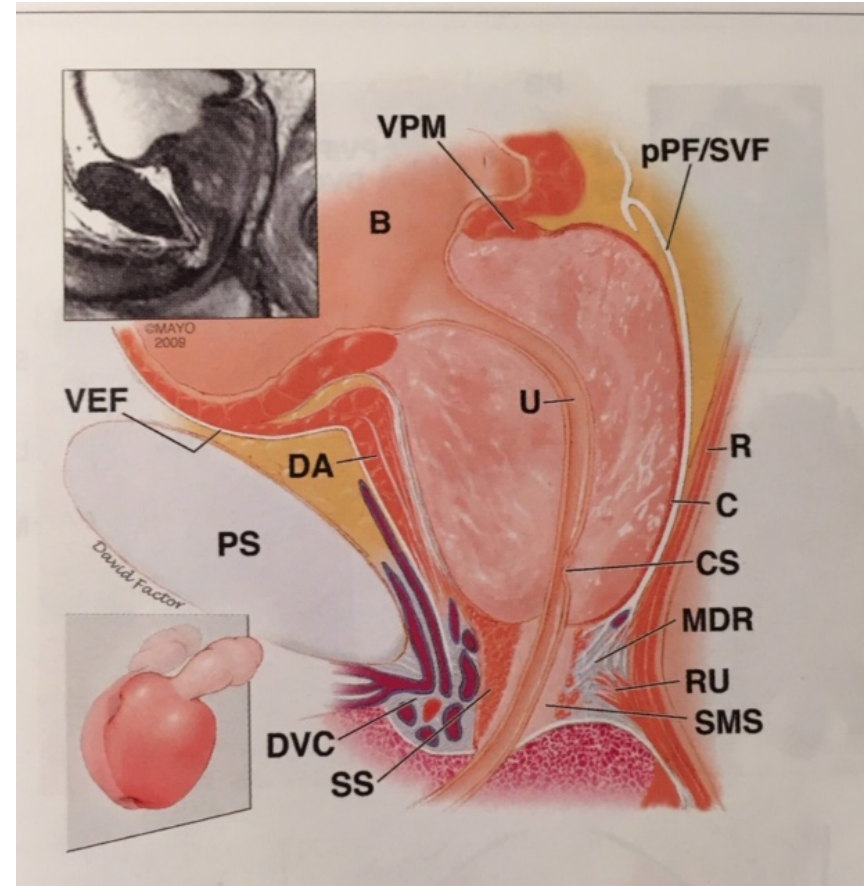
**3- Urinary  
continence**

# Complesso sfinterico

1. Collo vescicale (sfintere preprostatico)
2. Sfintere liscio uretrale
3. Rabdomiosfintere uretrale
4. Muscolo elevatore dell'ano

# Cenni di anatomia e fisiologia dello sfintere urinario

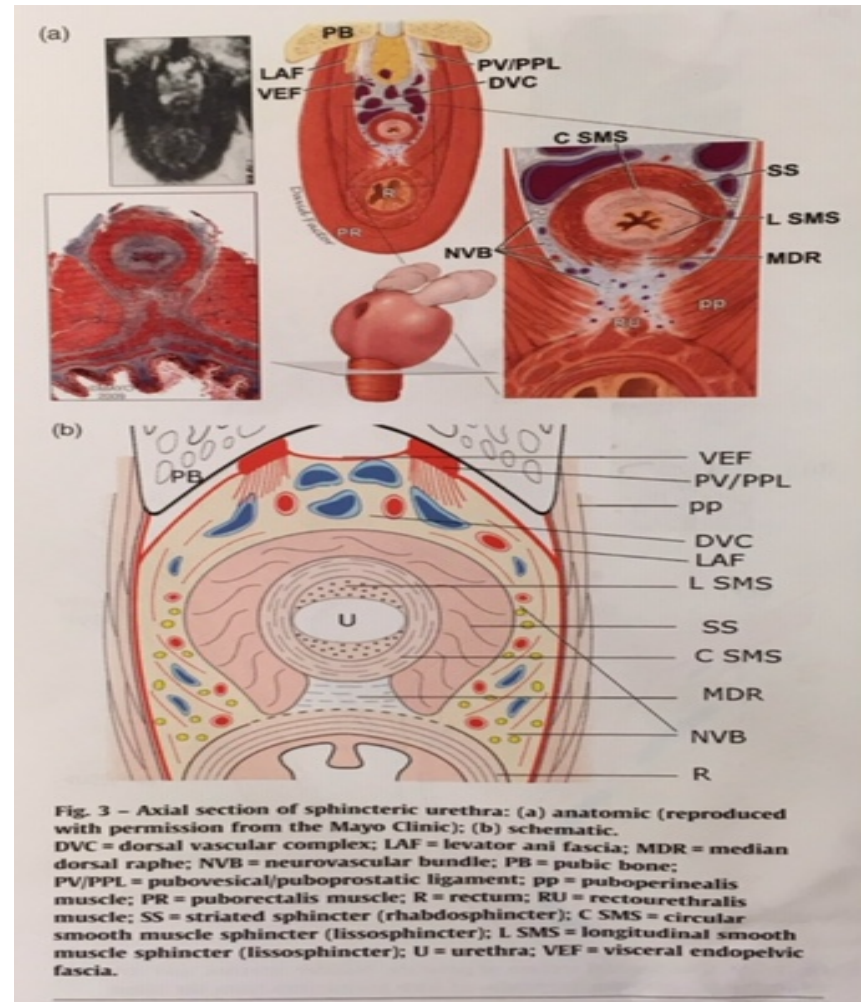
- Lo sfintere urinario si trova distalmente all'apice prostatico e si estende in maniera sfumata come un cilindro intorno all'uretra dall'orifizio vescicale all'uretra membranosa
- E' in contiguità, ma distinto dai muscoli pubo-perineale e del pavimento pelvico
- La porzione posteriore è in contiguità con la superficie anteriore del retto



# Cenni di anatomia dello sfintere urinario

Consiste di due strati muscolari

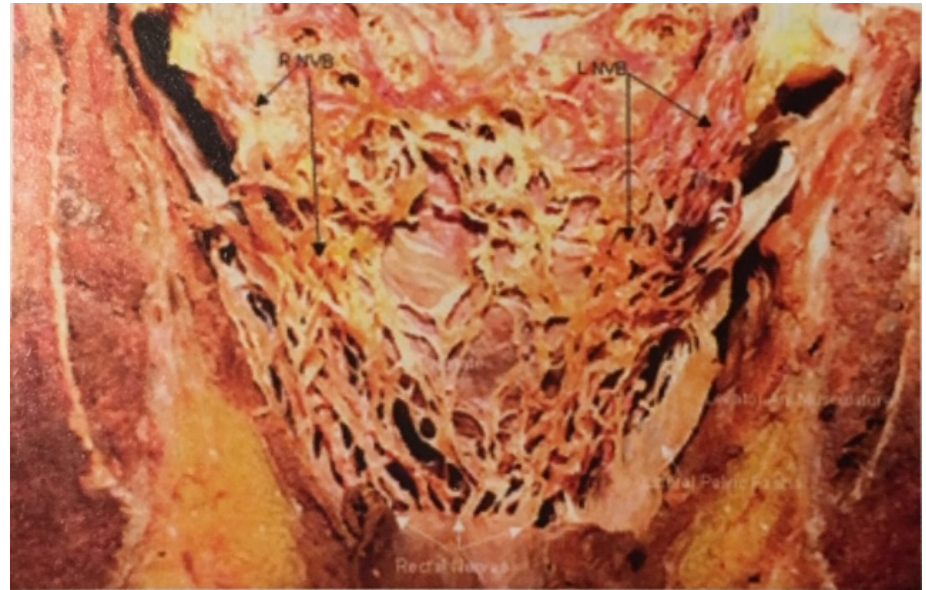
- La componente esterna (rbdomiosfintere) più spessa e rappresentata a livello dell'uretra membranosa e si assottiglia verso il complesso prostatico-vescicale. Le fibre non avvolgono completamente l'uretra, ma sfumano in un rafe fibroso posteriore che si fonde con il tendine perineale. L'aspetto in sezione ricorda quello di un ferro di cavallo
- La componente interna (sfintere liscio) circonda completamente l'uretra con doppio orientamento, uno strato circolare ed uno strato longitudinale



# Cenni di anatomia dello sfintere urinario

L'innervazione è fornita da rami del plesso pelvico che originano in parte dal nervo pudendo ed in parte dal NVB.

Le fibre nervose raggiungono lo sfintere in sede postero-laterale (ore 5 e 7 e ore 3 e 9)



# Cenni di fisiologia dello sfintere urinario

- La componente interna dello sfintere (sfintere liscio) è responsabile della continenza passiva grazie alla contrazione delle fibre circolari
- La contrazione del raddomiosfintere sul fulcro del rafe mediano post schiaccia l'uretra in senso caudale provocando l'avvicinamento della parete post a quella ant e lo schiacciamento contro il pube (double sling mechanism).

E' questo il meccanismo di continenza attiva operativo durante bruschi aumenti della pressione addominale e per l'interruzione volontaria della minzione.

# Complesso pubo-vescicale

- Complesso venoso-dorsale
- Detrusor apron – fibre muscolari originanti dalle fibre detrusoriali che ricoprono la superficie della prostata cranialmente
- Legamenti pubo-vescicali e pubo-prostatici – stabilizzano, uretra, prostata e vescica al pube e sono considerati parte importante del sistema di sospensione nel meccanismo di continenza attiva

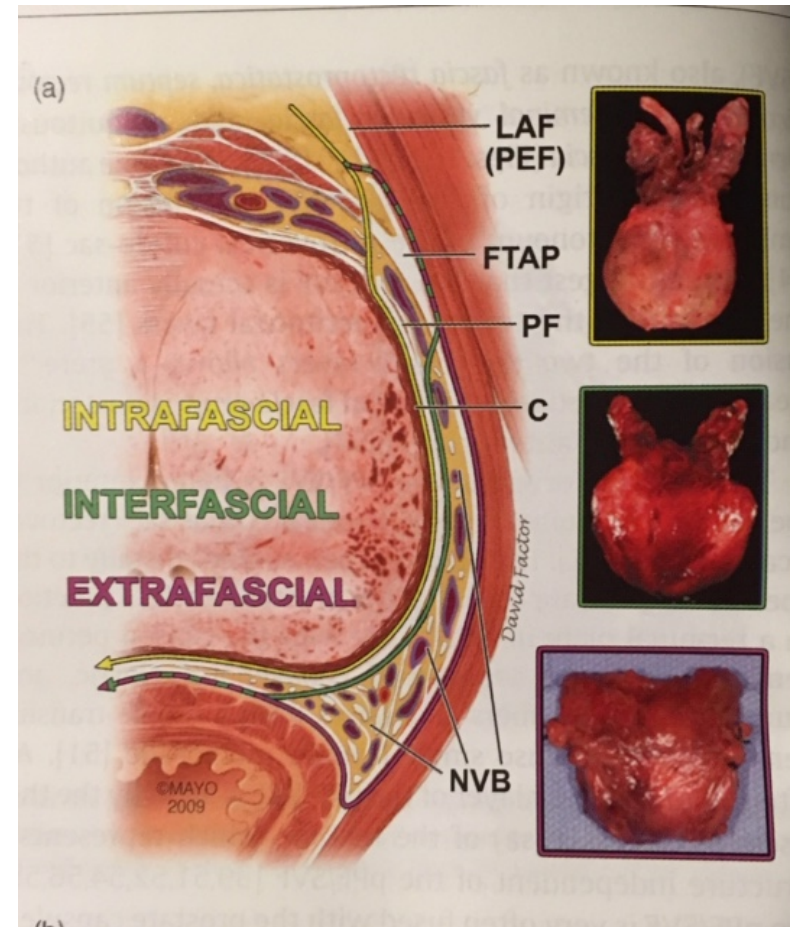


# Dissezione: caveat

- Isolare, ma con rispetto le strutture anatomiche (non devascularizzare, non denervare)
- Ricercare la massima lunghezza del moncone uretrale evitando di mobilizzare eccessivamente ed evitando il margine positivo

# Nerve sparing e continenza

- Confermato in RCTs: recupero precoce e migliore della continenza in pazienti sottoposti a nsPR



# Modifiche alla tecnica di Walsh

## *Zona prossimale*

- Bladder neck sparing
- Ricostruzione o intussuscezione del collo vescicale

## *Zona funzionale distale*

- Pubo-prostatic ligament sparing technique o ricostruzione anteriore
- Ricostruzione posteriore del complesso uretrosfinterico e sospensione totale del rabdomiosfintere

# Bladder neck sparing/ pubo-prostatic ligament sparing techniques

- Facilitano una ripresa precoce della continenza ma non influenzano le percentuali finali di recupero della stessa (Selli C. Scan J Urol 2004; Deliveliotis C- Urology 2002)
- Ridurrebbero il rischio di stenosi dell'anastomosi
- Rischio di margini chirurgici positivo contenuto (1-5%) (Bianoc Fj- Eur Urol 2003)

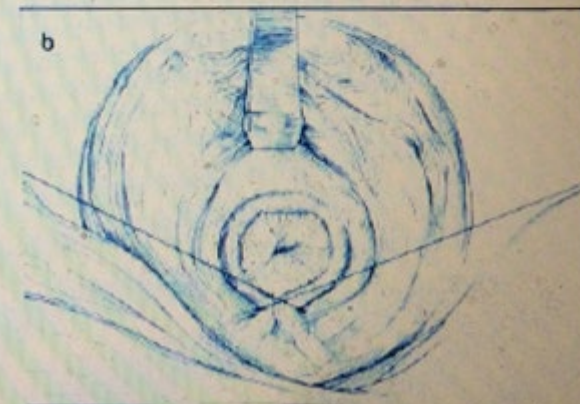
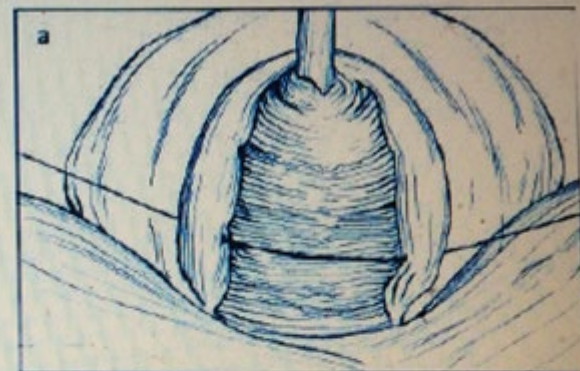
# Ricostruzione/intussuscezione del collo vescicale

*Influenzerebbe positivamente una continenza precoce*

**“Intussusception” reconstruction**



**The “Pagano” suture**



# Tecniche di anastomosi

Anastomosi in continua o a punti staccati

# Tecniche di anastomosi

- Non usare troppi punti: devascolarizzano e quindi riducono la lunghezza funzionale del moncone uretrale

*Muscolo legato* → *Muscolo perduto*

[Urol J. 2009 Summer;6\(3\):163-9.](#)

**Early continence after open and laparoscopic radical prostatectomy with sutureless vesicourethral alignment: an alternative technique, 8 years' experience.**

[Simforoosh N<sup>1</sup>](#), [Javaherforooshzadeh A](#), [Aminsharifi A](#), [Tabibi A](#).

[⊕ Author information](#)

*(324 pz) 95% di pz continenti, ma 15% di stenosi dell'anastomosi*

# Tecniche di anastomosi

## *Anastomosi in continua*

- precoce rimozione del catetere
- nulla possibilità di leakage urinoso
- drastica riduzione di incidenza stenosi dell'anastomosi

## *Open PR*

[J Urol. 2007 Jan;177\(1\):118-22; discussion 122.](#)

**Initial results using a running vesicourethral anastomosis following open radical retropubic prostatectomy.**

[Harpster LE<sup>1</sup>, Brien J.](#)

- Precoce rimozione del CV (4-6 giornata post-op)
- Nessun aumento di morbilità



## Technique for laparoscopic running urethrovesical anastomosis: the single knot method.

Van Velthoven RF<sup>1</sup>, Ahlering TE, Peltier A, Skarecky DW, Clayman RV.

### Author information

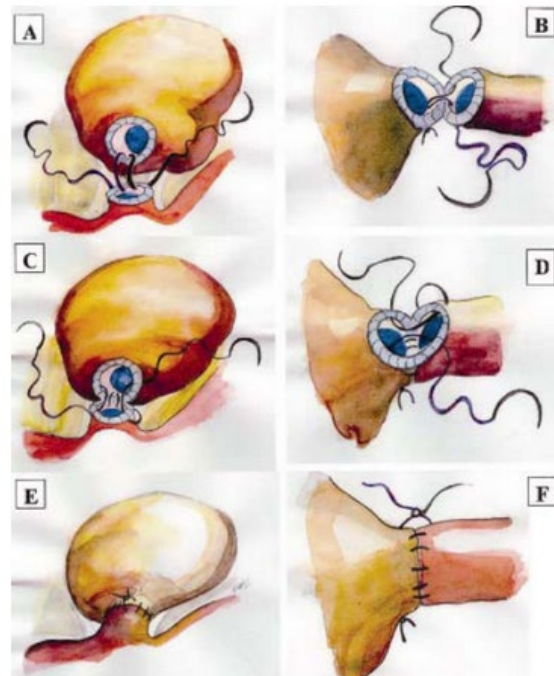
#### Abstract

**OBJECTIVES:** To describe a technique for facilitating the urethrovesical anastomosis at the time of laparoscopic radical prostatectomy.

**METHODS:** Two 6-in. polyglycolic acid sutures (one dyed, one white) are tied together at their tail ends and delivered into the operative field by way of a 12-mm port. A running suture is completed from the 6:30 to the 12:00-o'clock position and from the 5:30 to the 12:00-o'clock position, at the end of which a single intracorporeal tie is completed. The catheter is placed before completing the anterior row of sutures; the catheter is left in place for 5 to 7 days.

**RESULTS:** This anastomotic technique has been used in 122 laparoscopic radical prostatectomies and 8 robot-assisted laparoscopic radical prostatectomies. The average time for the anastomosis was 35 minutes (range 14 to 80). All anastomoses were watertight. No symptomatic postoperative urinary leaks have occurred, and no clinically evident clinical bladder neck contractures resulted.

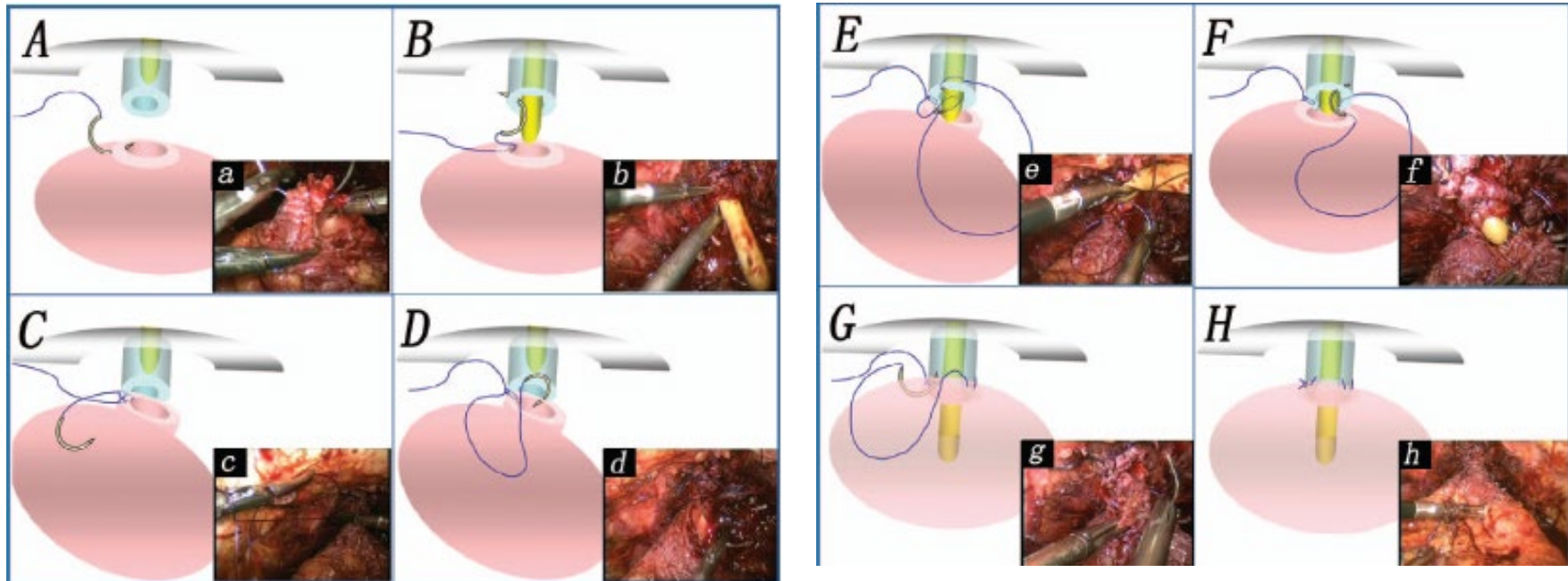
**CONCLUSIONS:** We describe a simple, watertight, running laparoscopic suture technique for accomplishing the urethrovesical anastomosis during laparoscopic radical prostatectomy.



**FIGURE 4.** Single-knot method for laparoscopic running urethrovesical anastomosis. (Reprinted from *Urology* 61(4), 699-702, 2003. With kind permission from Elsevier.)

## Continuous Suture of a Single Absorbable Suture: A New Simplified Vesicourethral Anastomosis Technique in Laparoscopic Radical Prostatectomy

Jie Yang,\* Peng-fei Shao,\* Qiang Lv, Ning-hong Song, Jie Li, Wei Zhang, Pu Li, Li-xin Hua, and Chang-jun Yin\*



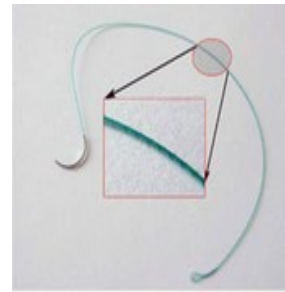
-300 pts

- time 8-30 minutes
- 2% urine leakage
- 1,5% bladder neck stenosis
- Continence rate 87% at 1 month; 93% at 3 m; 98% at 6 m

# The Use of Unidirectional Barbed Suture for Urethrovesical Anastomosis during Robot-Assisted Radical Prostatectomy: A Systematic Review and Meta-Analysis of Efficacy and Safety

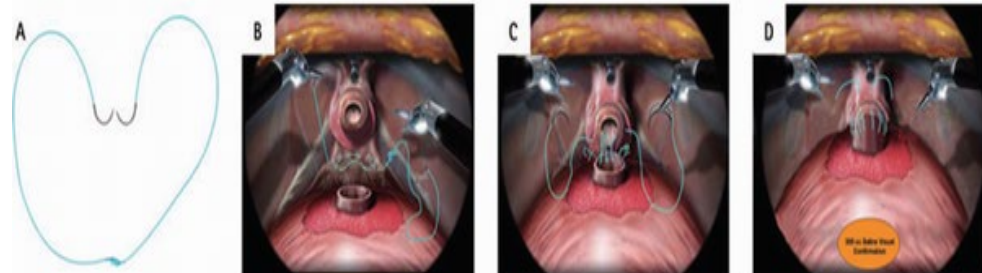
Huixin Li<sup>1,2\*</sup>, Chunxiao Liu<sup>2</sup>, Haibin Zhang<sup>1</sup>, Wenfeng Xu<sup>1</sup>, Jianhua Liu<sup>1</sup>, Yong Chen<sup>1</sup>, Tangxuan Li<sup>1</sup>, Bin Li<sup>1</sup>, Zhenquan Wu<sup>1</sup>, Taolin Xia<sup>1</sup>

- Unidirectional **barbed suture** safe and efficient as conventional suture
- Shorter anastomosis time
- Equivalent leakage, catheterization, continence rate at 4 e 6 months



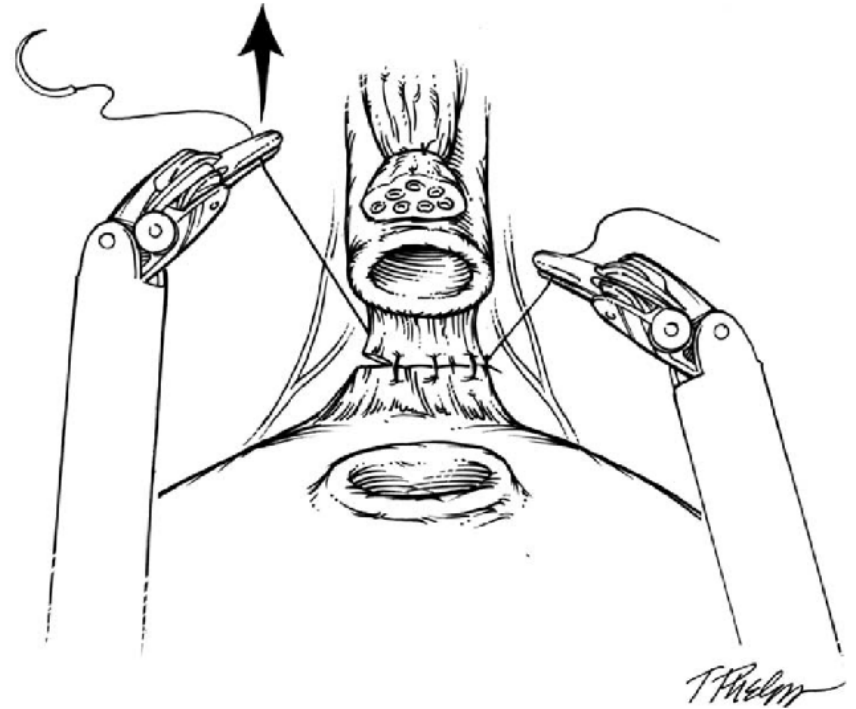
The Use of Unidirectional Barbed Suture for Urethrovesical Anastomosis during Robot-assisted Radical Prostatectomy

Safe  
Efficient



# Tecniche di anastomosi- Rocco stitch

- Ricostruzione del piatto muscolo-fasciale posteriore
- f. di Denonvillier e detrusore posteriore → raddomiosfintere uretrale
- Evita lo scivolamento distale del moncone uretrale (rafe mediano)
- Ricrea il double sling mechanism
- Anastomosi tension-free
- Favorisce la continenza precoce



Rocco stitch: 62% at 3 days, 74% at 30 days; 86% at 90 days  
Conventional: 14% at 3 days, 30% at 30 days; 46% at 90 days



# Ralp e Rocco stitch: tecnica originale

*Matteo Giulio Spinelli, Gabriele Cozzi, Angelica Grasso, Michele Talso, Daniela Varisco, Davide Abed El Rahman, Pietro Acquati, Giancarlo Albo, Bernardo Rocco, Augusto Maggioni, Francesco Rocco*

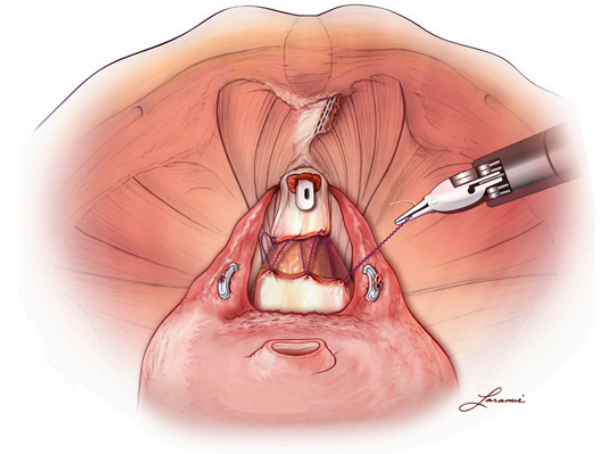
UO di Urologia, Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico, Università degli Studi di Milano - Italy

Per la ricostruzione si utilizzano due fili di sutura 3/0 in poliglecaprone (RB1) di differente colore con le estremità libere legate insieme. In alternativa possono essere utilizzati fili di sutura autostatici tipo Barbed per evitare di eseguire nodi e velocizzare ulteriormente questo tempo chirurgico. Le estremità libere della fascia di Denonvilliers risparmiati in corso di prostatectomia laparoscopica viene avvicinata al margine posteriore del raddosfintere e al rafe mediano posteriore utilizzando un capo della sutura continua in poliglecaprone.

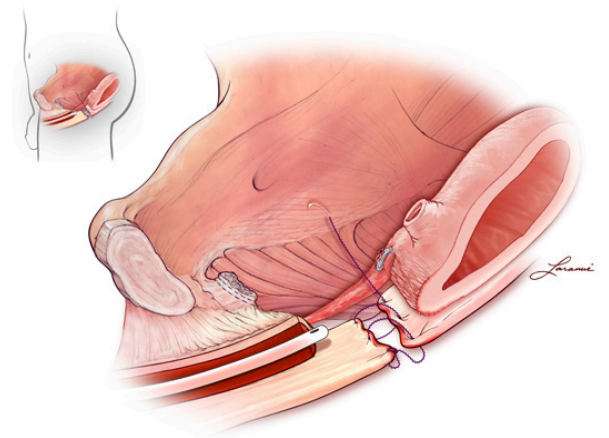
Per il secondo step della ricostruzione viene utilizzato il secondo capo della sutura. Questo strato avvicina la vescica, a circa 2 cm postero-superiormente al collo vescicale, allo strato posteriore del complesso raddosfintere/Denonvilliers e base vescicale.

Viene quindi confezionata un'anastomosi vescico-uretrale sec. Van Velthoven modificata (12).

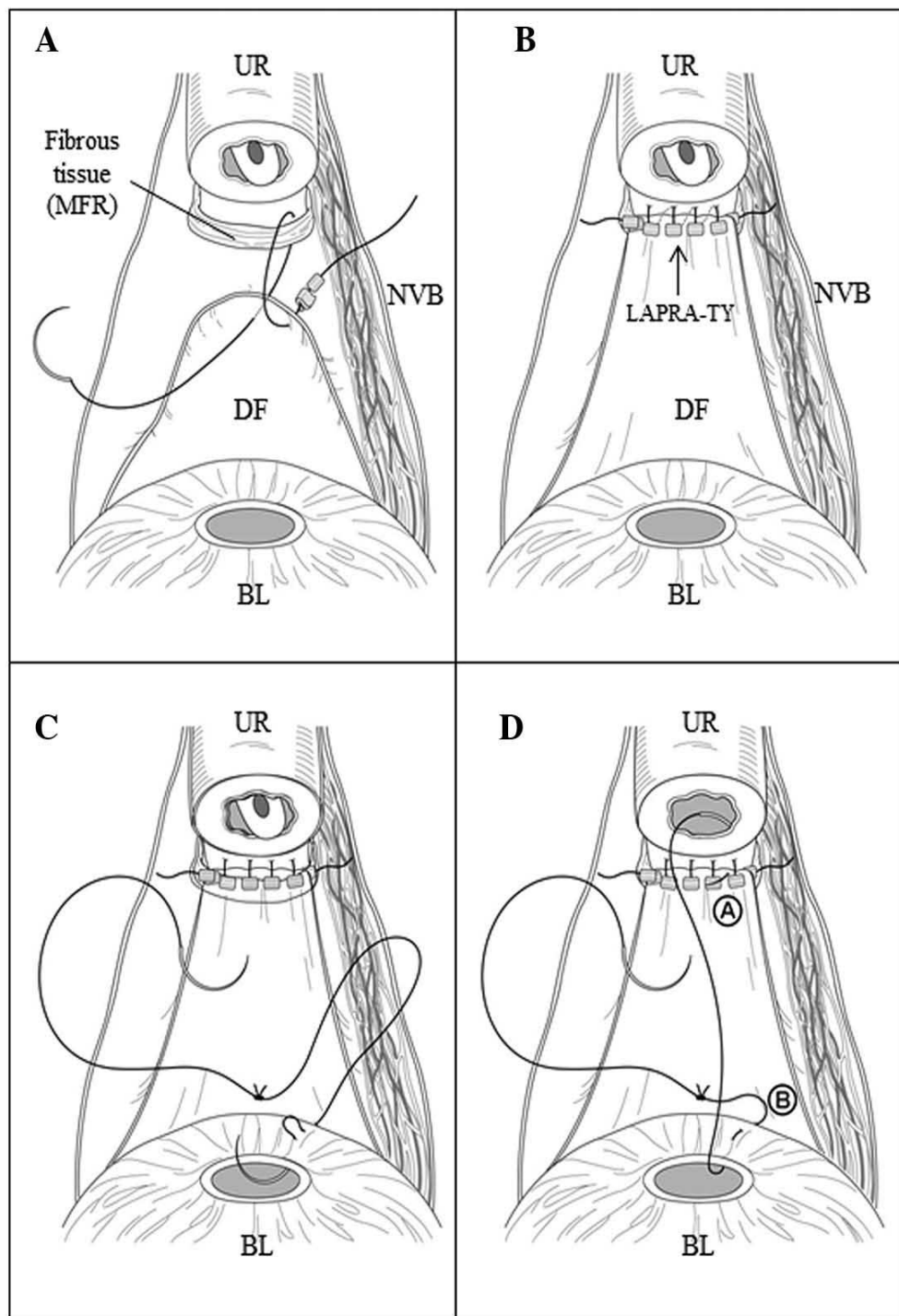
Patel ha inoltre proposto un'ulteriore modifica del secondo strato della ricostruzione posteriore che consiste in un avvicinamento del collo vescicale posteriore all'iniziale strato ricostruito tra raddosfintere posteriore e uretra posteriore (10).



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# Ralp e Rocco stitch: tecnica originale

*Matteo Giulio Spinelli, Gabriele Cozzi, Angelica Grasso, Michele Talso, Daniela Varisco, Davide Abed El Rahman, Pietro Acquati, Giancarlo Albo, Bernardo Rocco, Augusto Maggioni, Francesco Rocco*

UO di Urologia, Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico, Università degli Studi di Milano - Italy

L'effetto complessivo sulla statica pelvica maschile conseguente alla rimozione del blocco prostatovescicolare è costituito dalla:

- perdita del setto fibroso posteriore che garantisce una contrazione efficace al complesso uretro sfinterico
- slittamento caudale e accorciamento anatomico del complesso uretro-sfinterico soprattutto nel suo versante dorsale
- prolassamento posterocaudale della membrana perineale.

La tecnica è stata standardizzata per la procedura robotica da Coughlin et al effettuando modifiche minime.

Il tasso di continenza precoce (nessun pad ad 1 settimana) era del 58% (10).

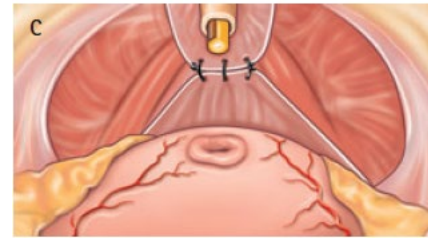
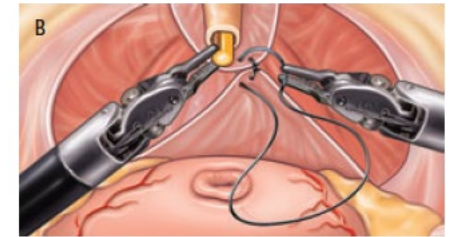
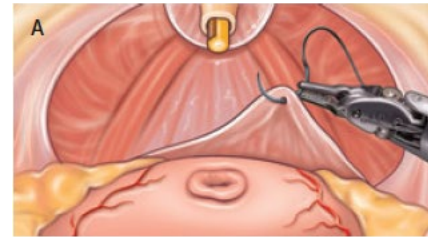
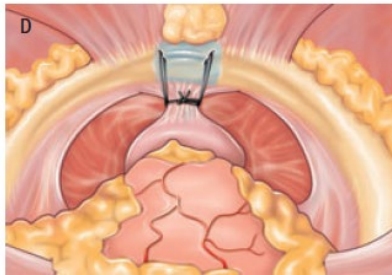
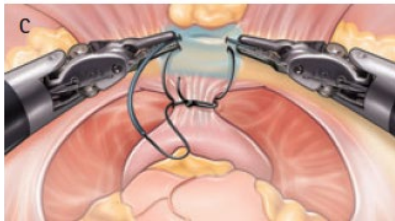
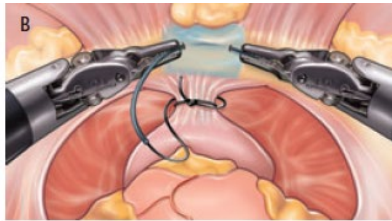
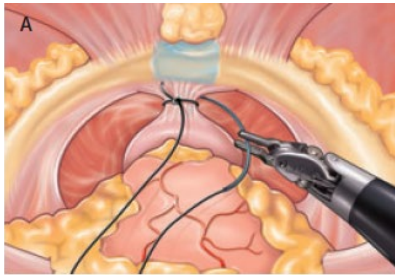
Nel 2006 Rocco et al hanno proposto un'ulteriore modifica alla tecnica chirurgica di Walsh che prevede di sospendere nuovamente l'emicirconferenza posteriore dello sfintere striato ad una struttura solida e fissa che costituisca l'ancoraggio craniale dello sfintere e restituisca allo sfintere stesso la sua naturale lunghezza anatomica ed un solido piano posteriore (7). Infine, il complesso uretro-sfinteriale deve essere posto in posizione corretta nella pelvi sospendendo il rafe mediano posteriore unito alla fascia di Denonvilliers alla vescica.

Oltre al vantaggio in termini di continenza, ulteriore merito della tecnica è la possibilità di effettuare un'anastomosi tension-free, poiché le suture del piano muscolo-fasciale sono strette prima di effettuare l'anastomosi (8). La ricostruzione del piano muscolo-fasciale è stata infatti associata ad un minor rischio di deiscenza anastomotica (9).

# Anterior suspension combined with posterior reconstruction during robot-assisted laparoscopic prostatectomy improves early return of urinary continence: a prospective randomized multicentre trial

Xavier Hurtes\*, Morgan Rouprêt<sup>†</sup>, Christophe Vaessen<sup>†</sup>, Helder Pereira\*, Benjamin Faivre d'Arcier\*, Luc Cormier<sup>†</sup> and Franck Bruyère\*

\*Urology Department, University Hospital of Tours, Tours, <sup>†</sup>Urology Department, Pitié-Salpêtrière Hospital, University Paris VI, Paris, and <sup>‡</sup>Urology Department, University Hospital of Dijon, Dijon, France



MIGLIORI RISULTATI IN TERMINI DI CONTINENZA PRECOCE SENZA AUMENTO COMPLICANZE





## Laparoscopic “single knot–single running” suture vesico-urethral anastomosis with posterior musculofascial reconstruction

[Authors](#)

[Authors and affiliations](#)

Giuseppe Simone , Rocco Papalia, Mariaconsiglia Ferriero, Salvatore Guaglianone, Michele Gallucci

*Conventional Van Velthoven* **vs** Single knot – single running

Tempo chirurgico comparabile

Continence rate statisticamente significativa a 1 e 3 mesi

# Total Anatomical Reconstruction During Robot-assisted Radical Prostatectomy: Implications on Early Recovery of Urinary Continence

*Francesco Porpiglia<sup>a,\*</sup>, Riccardo Bertolo<sup>a</sup>, Matteo Manfredi<sup>a</sup>, Stefano De Luca<sup>a</sup>, Enrico Checcucci<sup>a</sup>, Ivano Morra<sup>a</sup>, Roberto Passera<sup>b</sup>, Cristian Fiori<sup>a</sup>*

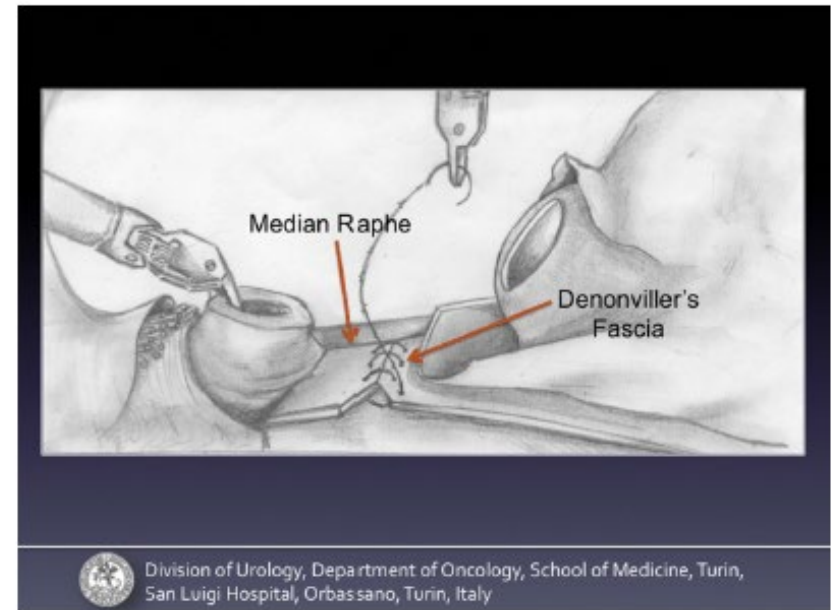
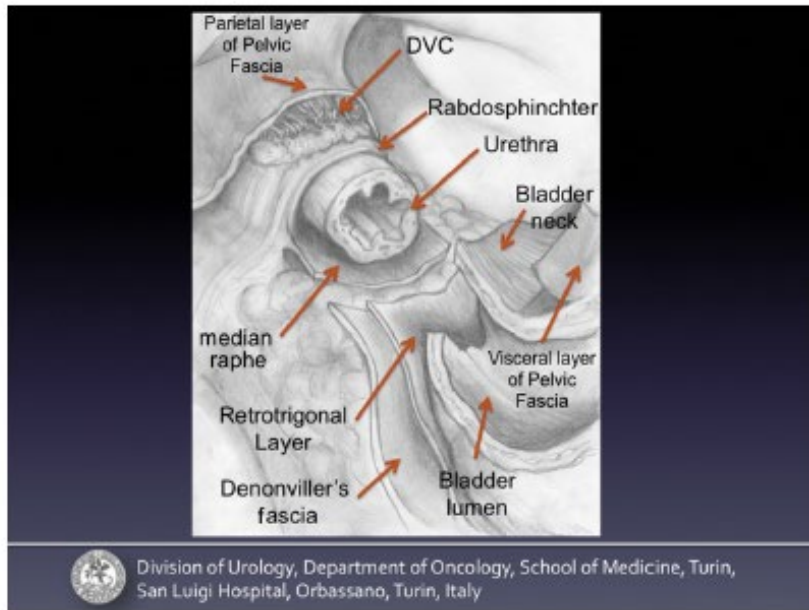
<sup>a</sup> Division of Urology, Department of Oncology, University of Turin, San Luigi Hospital, Orbassano, Turin, Italy; <sup>b</sup> Division of Nuclear Medicine, San Giovanni Battista Hospital, University of Torino, Turin, Italy

- To describe the total anatomical reconstruction (TAR) technique during robot-assisted radical prostatectomy (RARP)
- *Primary endpoint: evaluation of the continence rate at different time points*
- *Secondary endpoint: evaluation of urine leakage and anastomosis stenosis rates related to the technique*

# Total Anatomical Reconstruction During Robot-assisted Radical Prostatectomy: Implications on Early Recovery of Urinary Continence

Francesco Porpiglia<sup>a,\*</sup>, Riccardo Bertolo<sup>a</sup>, Matteo Manfredi<sup>a</sup>, Stefano De Luca<sup>a</sup>, Enrico Checcucci<sup>a</sup>, Ivano Morra<sup>a</sup>, Roberto Passera<sup>b</sup>, Cristian Fiori<sup>a</sup>

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**Fig. 1 – Operative field at the end of the extirpative phase. Anatomical landmarks are reported in the figure.**  
DVC = deep venous complex.

**Fig. 3 – Lateral view. First layer of posterior reconstruction: the needle is passed through the cranial portion of previously sectioned Denonvilliers' fascia and the median raphe moving from right to left.**

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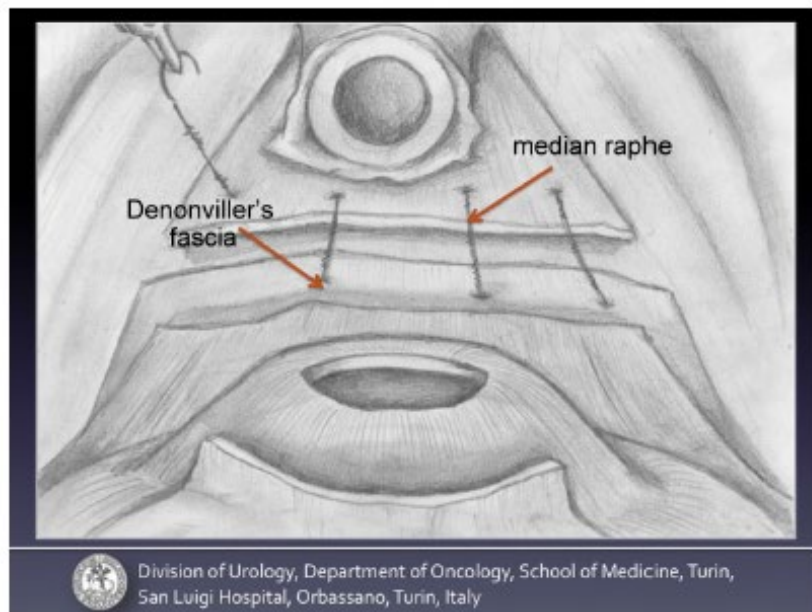


Fig. 2 – Frontal view. First layer of posterior reconstruction: the needle is passed through the cranial portion of previously sectioned Denonvilliers' fascia and the median raphe moving from right to left.

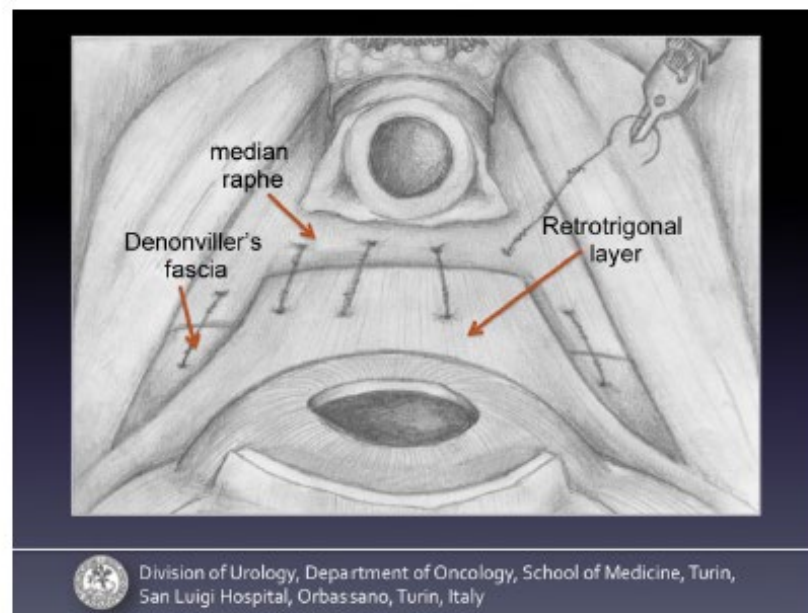


Fig. 4 – Frontal view. The second layer involves the retrotrigonal fascia and the median raphe moving from left to right.



# Total Anatomical Reconstruction During Robot-assisted Radical Prostatectomy: Implications on Early Recovery of Urinary Continence

Francesco Porpiglia<sup>a,\*</sup>, Riccardo Bertolo<sup>a</sup>, Matteo Manfredi<sup>a</sup>, Stefano De Luca<sup>a</sup>, Enrico Checcucci<sup>a</sup>, Ivano Morra<sup>a</sup>, Roberto Passera<sup>b</sup>, Cristian Fiori<sup>a</sup>

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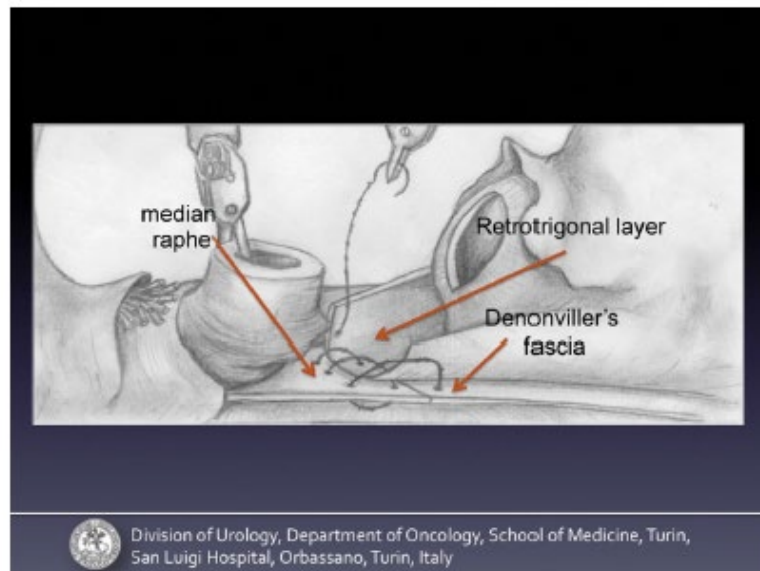


Fig. 5 – Lateral view. The second layer involves the retrotrigonal fascia and the median raphe moving from left to right.

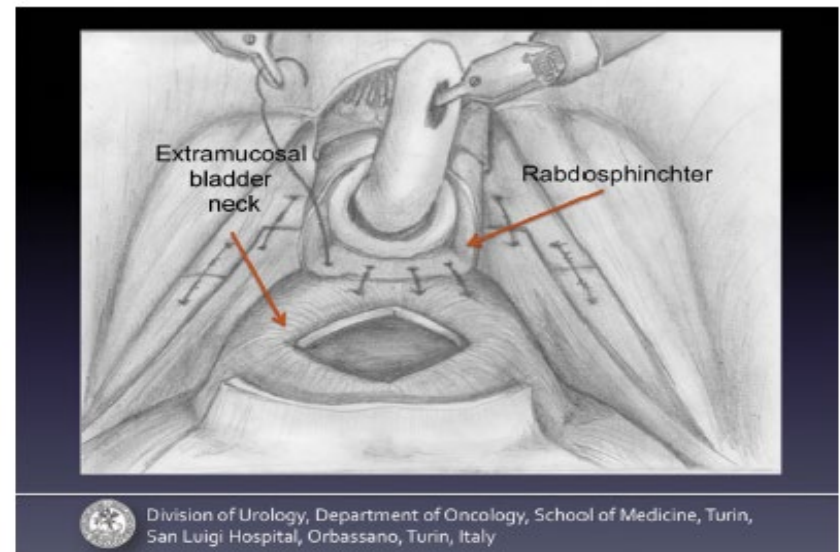
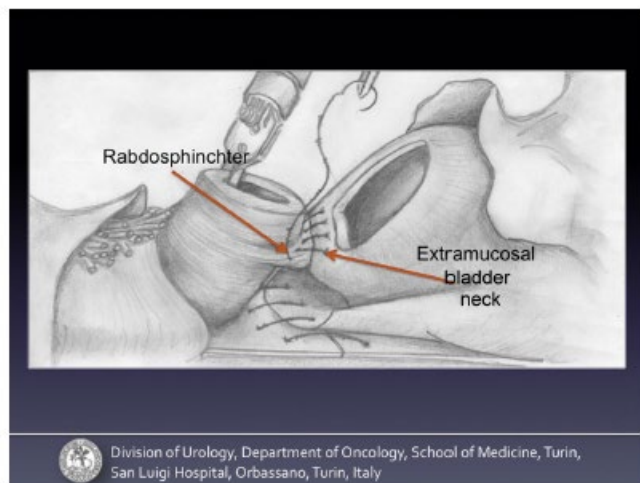


Fig. 6 – Frontal view. The third layer involves the bladder neck (excluding the mucosa of the bladder) and the posterior aspect of the rhabdosphincter again moving from right to left.

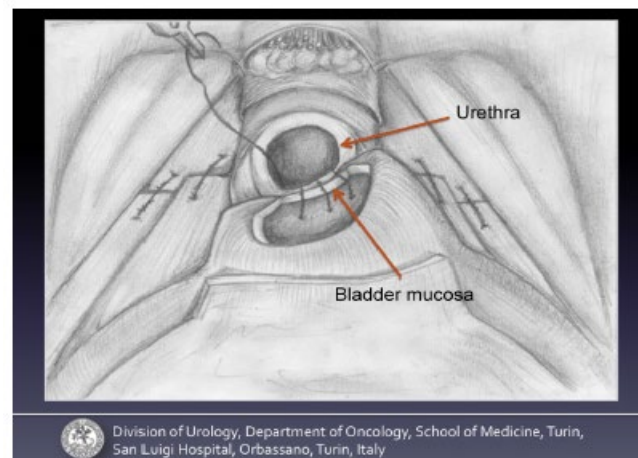
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**Fig. 7 – Lateral view.** The third layer involves the bladder neck (excluding the mucosa of the bladder) and the posterior aspect of the rhabdosphincter again moving from right to left.

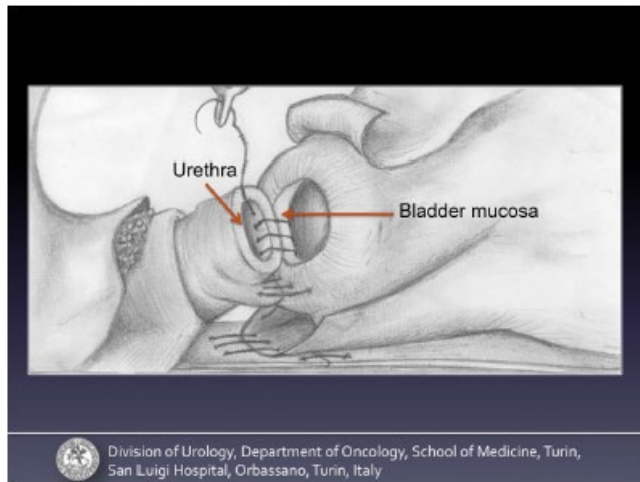


**Fig. 8 – Frontal view.** The urethro-vesical anastomosis performed by a 3/0 “barbed” running suture, starting at 4 o’clock on the urethra and proceeding clockwise. The suture involves the full thickness of either the bladder or the urethra.

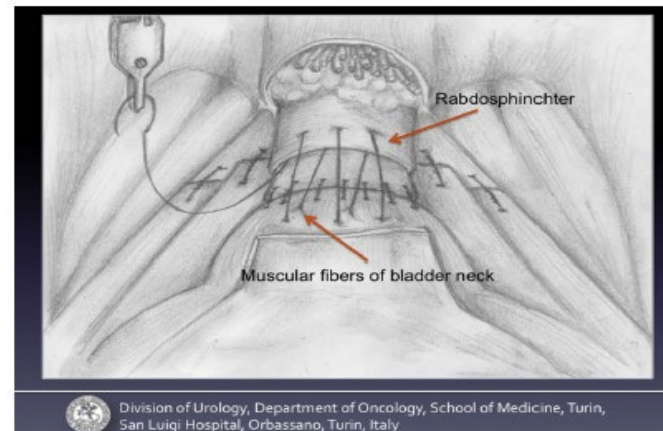
# Total Anatomical Reconstruction During Robot-assisted Radical Prostatectomy: Implications on Early Recovery of Urinary Continence

*Francesco Porpiglia<sup>a,\*</sup>, Riccardo Bertolo<sup>a</sup>, Matteo Manfredi<sup>a</sup>, Stefano De Luca<sup>a</sup>, Enrico Checcucci<sup>a</sup>, Ivano Morra<sup>a</sup>, Roberto Passera<sup>b</sup>, Cristian Fiori<sup>a</sup>*

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**Fig. 9 – Lateral view.** The urethro-vesical anastomosis performed by a 3/0 “barbed” running suture, starting at 4 o’clock on the urethra and proceeding clockwise. The suture involves the full thickness of either the bladder or the urethra.



**Fig. 10 – Frontal view.** Beginning from the right side and moving to the left, the muscular fibers of the bladder are 3/0 “barbed” running sutured to the previously dissected peri-urethral tissue located between the urethra and the deep venous complex both to restore the original anatomy by reallocating it towards the abdominal cavity and to reinforce the anastomosis.



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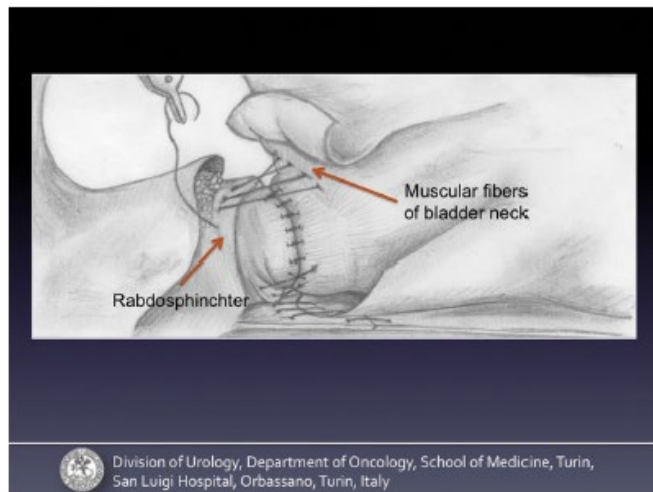


Fig. 11 – Lateral view. Beginning from the right side and moving to the left, the muscular fibers of the bladder are 3/0 “barbed” running sutured to the previously dissected peri-urethral tissue located between the urethra and the deep venous complex both to restore the original anatomy by reallocating it towards the abdominal cavity and to reinforce the anastomosis.

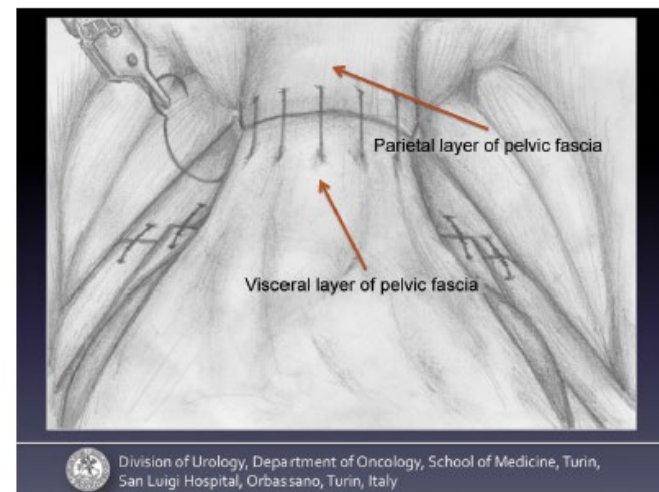


Fig. 12 – Frontal view. Moving from left to right, the visceral layer of the endopelvic fascia and the underlying apron, still covering the anterior surface of the bladder, are sutured to the portion of the endopelvic fascia that covers the deep venous complex while involving the pubo-prostatic ligaments such that they can be renamed “pubo-vescical” ligaments.



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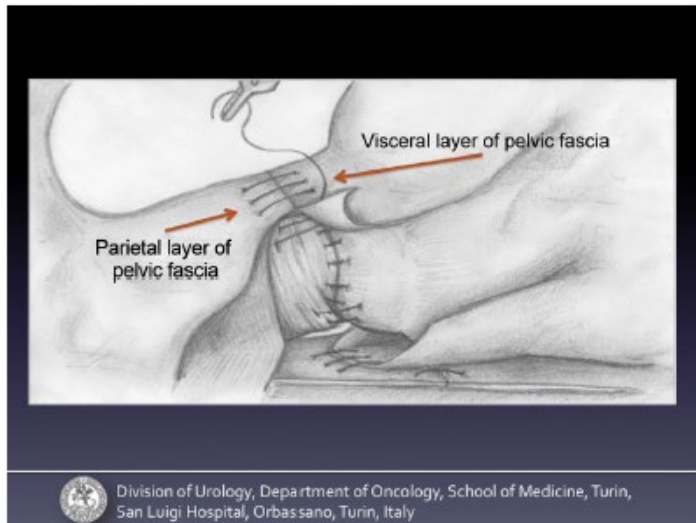


Fig. 13 – Lateral view. Moving from left to right, the visceral layer of the endopelvic fascia and the underlying apron, still covering the anterior surface of the bladder, are sutured to the portion of the endopelvic fascia that covers the deep venous complex while involving the pubo-prostatic ligaments such that they can be renamed “pubo-vesical” ligaments.

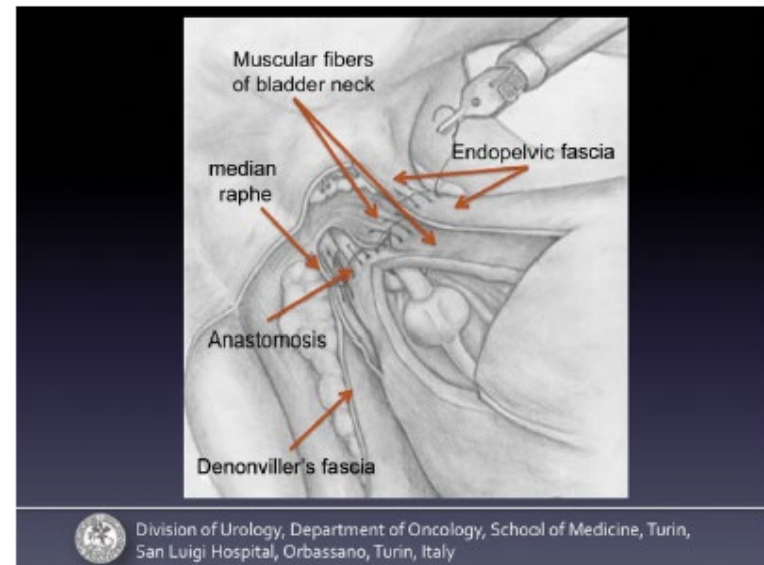
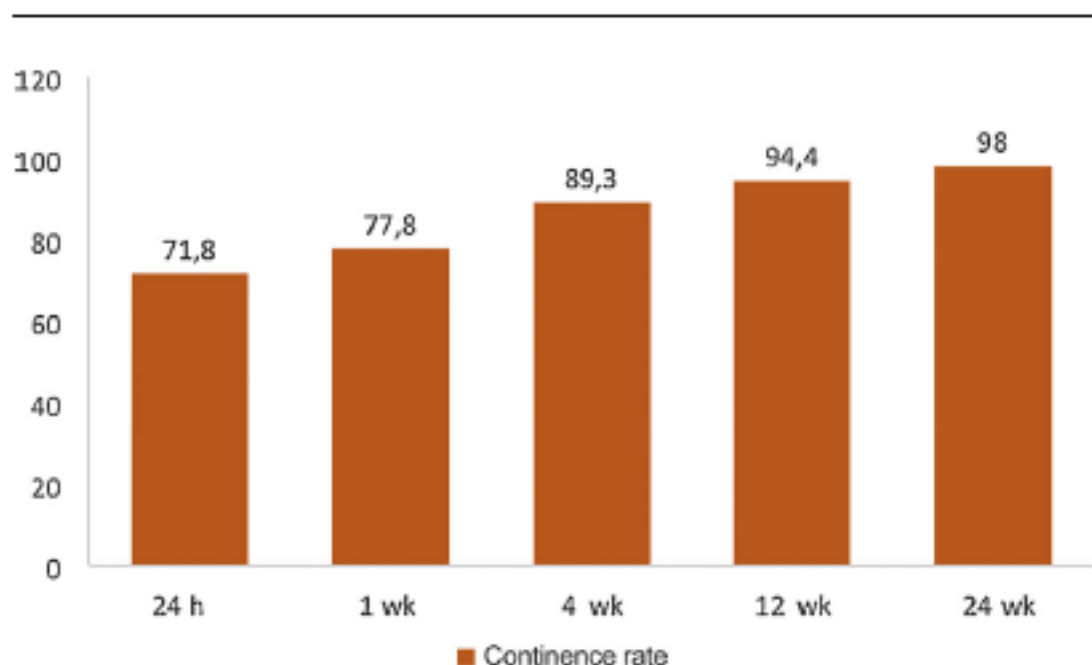


Fig. 14 – At the end of the reconstructive phase, the anastomosis is protected by three posterior layers and two anterior layers, with a full restoration of the anatomy of the peri-urethral structures.

# Total Anatomical Reconstruction During Robot-assisted Radical Prostatectomy: Implications on Early Recovery of Urinary Continence

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**Fig. 16 – Histogram showing continence rates at different time points.**

# Half-day case robotic radical prostatectomy. Surgery of the future? A case report

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This report highlights the first, half-day, robotic prostatectomy performed on a 57-year-old man with localized prostate cancer. This operation was proposed to the subject because of his excellent physical condition and favorable environmental factors. He chose to undergo the surgery voluntarily. He underwent a nerve sparing radical prostatectomy.

Hospital stay less than 12 hours.

Ambulatory robotic radical prostatectomies can be performed on voluntarily-selected patients without affecting the high quality of urological surgery outcomes.

## **Early Catheter Removal after Robot-assisted Radical Prostatectomy: Surgical Technique and Outcomes for the Aalst Technique (ECaRemA Study).**

Gratzke C<sup>1</sup>, Dovey Z<sup>2</sup>, Novara G<sup>3</sup>, Geurts N<sup>4</sup>, De Groot R<sup>4</sup>, Schatteman P<sup>4</sup>, de Naeyer G<sup>4</sup>, Gandaqlia G<sup>5</sup>, Mottrie A<sup>6</sup>.

We provide evidence that is possible to remove the bladder catheter as early as 2 d after RARP without any negative effects on voiding and pain parameters. Thus, leaving the hospital early without the catheter in place could represent a significant and relevant benefit for the patient