

**Conclusions:** In this pilot study in a rabbit model the haemostatic effect of fibrin glue was confirmed on covering a defect in the tunica albuginea. Moreover, there was regeneration of normal tunica albuginea with no scarring at 6 weeks and maintained at 12 weeks. Further well-controlled studies are required before using fibrin glue for corporal body grafting to treat chordee.

### **Editorial Comment**

Many materials have been investigated for corporal body grafting in surgical correction of chordee and Peyronie's disease (porcine small intestinal submucosa and tunica acellular matrix, as examples). This article evaluated the feasibility of using a commercially available fibrin glue ('Tisseel', Baxter Healthcare Corp., Irvine, California) for covering corporal body defects, with potential application in the surgical management of severe chordee. In rabbits, the results were excellent. Fibrin glue may be considered a suitable substance for corporal body grafting in the future.

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## **RECONSTRUCTIVE UROLOGY**

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### **Complete primary repair of bladder exstrophy: initial experience with 33 cases**

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**Purpose:** We evaluated our initial experience with complete primary repair of bladder exstrophy in 33 children.

**Materials and Methods:** Between 1998 and 2001, 33 children with classic bladder exstrophy were treated with 1-stage primary repair for the first time in all except 4, who had undergone previous failed initial bladder closure. Our series included 26 boys and 7 girls with a mean age of 2 months (range 3 weeks to 14 months). The bladder was closed in continuity with the urethra and complete penile disassembly was used for epispadias repair. Anterior transverse innominate osteotomy was performed in all cases. Combined general and caudal anaesthesia were applied in all cases with an indwelling epidural caudal catheter in 7.

**Results:** Median followup was 42 months (range 24 to 62). Enterocystoplasty was needed in 3 cases during primary repair of a small bladder plate. Wound dehiscence was not recorded. Bladder neck fistula was reported in 2 children, while urethral fistula was recorded in 1 boy. Abdominal ultrasound detected no hydro-nephrosis in all except 3 patients. Voiding cystourethrogram showed vesicoureteral reflux in 6 patients. No loss of renal function or febrile urinary tract infection was recorded. A dry interval of 3 hours or greater was reported in 24 children (72.7%), while 9 who were incontinent of urine after failed toilet training needed other procedures to achieve continence.

**Conclusions:** Complete primary repair with penile disassembly provides a good approach to achieve this purpose without the need for bladder neck reconstruction in some cases. Selection of the proper surgical technique together with adjunctive procedures such as osteotomy and a pain-free early postoperative period can maximize the chance of successful exstrophy repair.

### Editorial Comment

Reconstruction of the bladder, bladder neck and urethra in bladder exstrophy patients is still a major challenge for a reconstructive urologist. The series presented here with 33 children out of whom 29 underwent a 1-stage primary repair for the first time is probably the largest series to date. All operations were done in boys and girls less than 14 months old. Preoperative assessment was simple with an intravenous pyelography or abdominal ultrasound. All surgical interventions were done by the same pediatric urologist in all cases. Apart from a well documented surgical technique, meticulous surgical handling was probably the most important factor for having better results than in many other series. There was a 76% continence rate in all children at a toilet trained age. Only three patients - those that underwent enterocystoplasty - were only continent on clean intermittent catheterization.

It is remarkable that incision of the muscular bladder wall is a possible way to increase bladder capacity in those children where the bladder template is too small. It is here that tissue engineering at some time may become useful when earlier (maybe in utero) biopsy harvests may be expanded in the laboratory to be used to increase the detrusor. The bulging or expanding mucosa usually is not the problem especially not in very young children.

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### **Lymphadenectomy with cystectomy: is it necessary and what is its extent?**

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**No Abstract Available**

### Editorial Comment

Several decades ago, well known urologic surgeons in the field made it clear that lymphadenectomy is an important part of anterior exenteration. It was, however, thought to be useful only for staging. More recent reports, however, both from the USA and Europe have shown that patients with minimal involvement of lymph nodes and curable primary transitional cell cancer of the bladder may survive even without further adjuvant treatment. This means that nodal disease defined as N-1 in the TNM system can be cured surgically, at least in some cases. In one larger report the authors even found the T-stage to be more important and the actual prognostic factor for survival regardless whether patients were staged as N-0 or N-1 [1]. This prompted some authors to propose an extension of pelvic lymphadenectomy cranially to the common iliac and the para-aortic region.

The para-aortic and especially the common iliac region were the main trunk of the sympathetic fibers supplying the hypogastric plexus could be found. The division of these fibers may lead to functional problems in the remnant urethra in patients undergoing an orthotopic neobladder after cystectomy [2]. The present paper by two well-known experienced surgeons is a well worked-up series of 200 patients undergoing radical cystectomy and extended lymphadenectomy. Only two surgeons performed all cystectomies, thereby reducing the possibility of an operator dependent variation. The nodes from each anatomic region were sent on a separate template for pathologic evaluation. It was demonstrated that none of the patients with minimal lymph node disease-and those were the ones that had a chance of cure-had nodal involvement outside the pelvic region.

They did find extrapelvic nodal disease, but in all cases these pN2 patients. Most of us agree with the authors' conclusion that these are not the patients which can be cured surgically.

For reconstructive purposes it is important that we can limit our lymphadenectomy in certain patients to a level where we do not have to dissect the sympathetic autonomic nerve supply to the hypogastric plexus and pelvic floor. Thereby functional results of an orthotopic neobladder and vagina can be improved without compromising oncological results.

### References

1. Vieweg J, Gschwend JE, Herr HW, Fair WR: The impact of primary stage on survival in patients with lymph node positive bladder cancer. *J Urol.* 1999; 161: 72-6.
2. Stenzl A, Colleselli K, Bartsch G: Update of urethra-sparing approaches in cystectomy in women. *World J Urol.* 1997; 15: 134-8.

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## UROLOGICAL ONCOLOGY

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### **Post-brachytherapy transurethral resection of the prostate in patients with localized prostate cancer**

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**Purpose:** We assessed the rate and results of transurethral resection of the prostate (TURP) in patients previously treated with brachytherapy as monotherapy for localized prostate cancer.

**Materials and Methods:** From May 1998 to May 2003, 600 patients with localized prostate cancer were treated with brachytherapy at our institution. Brachytherapy was performed as monotherapy with curative intent for clinically localized prostate cancer without adjuvant treatment in patients with clinical stages T1c (68.4%) or T2a (31.6%) disease. -Iodine and palladium implants were used in 583 and 7 patients, respectively. A real-time interactive implantation technique was used in all but the first 17 patients, who were treated using a preplanned technique.

**Results:** Of the 600 patients 19 (3.1%) underwent TURP after brachytherapy. Among the patients with acute urinary retention the median interval between prostate brachytherapy and urinary retention was 2 months (range 0.5 to 32). No TURP was done within 6 months after implant. The median interval between prostate brachytherapy and TURP was 7 months (range 6 to 41) and median prostate specific antigen (PSA) before TURP was 0.5 ng/ml (range 0.04 to 3.4). In the 19 patients the median weight of resected prostatic tissue was 8 gm (range 2 to 19) and 1 to 11 seeds were removed (median 5). The perioperative and postoperative courses were uneventful. There was no TURP related incontinence. With a median followup of 28 months after brachytherapy (range 7 to 48) no patient had clinical or biochemical evidence of disease progression, and for the group of 19 patients who underwent TURP median serum PSA at the end of followup was 0.38 ng/ml (range 0.03 to 3.4).

**Conclusions:** After brachytherapy as monotherapy, TURP can be done safely if indicated. In our experience the resection of prostatic tissue along with a limited number of seeds at least 6 months after implantation did not impair PSA based biological and clinical results of brachy-therapy.