



Single Port Transvesical Prostatectomy

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ABSTRACT

Purpose: To describe a case of a transvesical prostatectomy performed by a single port technique.

Patient and Methods: JLS, 64y, diabetic and hypertense, under treatment of LUTS for 8 years with 4mg doxazosin and 5mg finasteride. The IPSS score was 26. The digital rectal exam showed a more than 60g benign prostate. The Body Mass Index was 28.9. The total PSA was 5.4ng/mL and the free/total PSA was 22%. A 12-fragments prostate biopsy showed BPH. The sonography revealed a 106g prostate and the maximum urinary flow was 12 ml/s. The patient was under general anesthesia and was positioned in dorsal decubitus with Trendelenburg. The bladder was filled until that a bexigoma was visible. A 2 cm longitudinal infra-umbelical incision was done. The Gel Point Single Port System (Applied, Ca, USA) was placed inside the bladder and the pneumovesicum was done until 10mmHg. A peri-bladder neck incision was done and the adenoma dissection was performed until its remotion. The hemostasia was done under vision. A 3-way 24-Fr Foley catheter and an 8-Fr plastic catheter were placed inside the bladder. The adenoma was removed and the bladder and the abdominal wall were closed.

Results: The procedure took 55 minutes and the blood loss was 180 ml. The patient evolved uneventfully, the bladder irrigation stayed for 24 h, the hemoglobin drop was 2.4g/dL and the patient was discharge after 36 hours. The urethral catheters stayed for 5 days. The postoperative IPSS was 6 and the maximum flow was 26 ml/s.

Conclusion: The surgery was safe and effective, showing that the single port transvesical prostatectomy can be an option in the surgical treatment of large prostates.

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EDITORIAL COMMENT

In this video by Vicentini et al., the authors employ a novel single port transvesical approach for the surgical management of benign prostatic hyperplasia (BPH). I applaud the authors on employing such a well suited minimally invasive surgical approach to BPH refractory to current medical therapies. As a host of alternate surgical therapies arise for BPH including Holmium-YAG laser enucleation/vaporization and Greenlight laser vaporization, the ultimate question is which one provides the best outcomes in terms of long-term improved urinary stream, minimal irritative post-treatment voiding symptoms, optimal surgical outcomes (i.e. quickest convalescence, less

perioperative pain, decreased blood loss/necessity for blood transfusion, and lowest risk of complications), as well as the ever increasing concern of treatment specific healthcare cost. Clearly, this is a complex question which can't be answered through a single video presentation or case series but will require multi-arm prospective studies to be conducted. I encourage the urological society at large to consider doing such studies because it is only through such efforts that we can ultimately answer the question of what is the best option. It is likely that certain patients may do better with one specific surgical option versus another based on the size of the gland, specific surgical anatomy e.g. prominent median lobe, and baseline irritative voiding symptoms.

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