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### Title

85 SINGLE-STAGE SEGMENTAL NEOURETHRAL FORMATION WITH VENTRAL ONLAY FASCIOCUTANEOUS FLAP AND DORSAL BUCCAL URETHRAL PLATE REPLACEMENT

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### Authors

Erickson, Bradley  
Breyer, Benjamin  
McAninch, Jack

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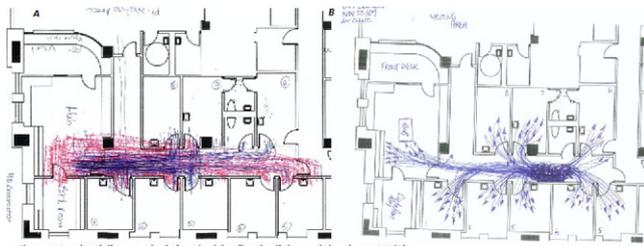


Figure 1. Spaghetti diagrams depicting physician flow in clinic pre- (A) and post-RIE (B).

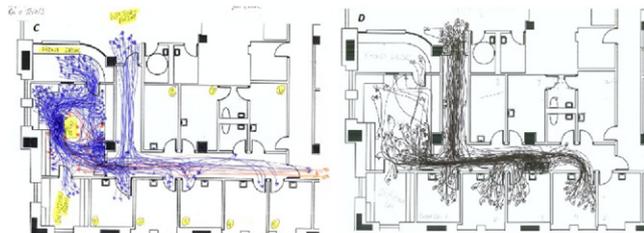


Figure 2. Spaghetti diagrams depicting nurse flow in clinic pre- (C) and post-RIE (D).

Table 1. Improvement from baseline following Rapid Improvement Event

	Baseline	30 days	60 days	90 days
Average Number of Patients per Clinic	30.4	32.1	32.6	31.2
Median Cycle Time (min)	46	43	31*	n/a
Wait Time for Initial Assessment (min)	23	5*	10*	5*
RN Quick Assessment (min)	0.5	15*	5*	5*
RN Teaching (min)	2	n/a	15*	10*
Wait Time for Clinical Trial Coordinators (min)	26	18*	6*	n/a

\* p &lt; 0.05 compared to baseline

Source of Funding: None

## Trauma/Reconstruction: Trauma & Reconstructive Surgery

### Moderated Poster 7

Saturday, May 14, 2011

3:30 PM-5:30 PM

## 85

### SINGLE-STAGE SEGMENTAL NEourethRAL FORMATION WITH VENTRAL ONLAY FASCIOCUTANEOUS FLAP AND DORSAL BUCCAL URETHRAL PLATE REPLACEMENT

Bradley Erickson\*, Iowa City, IA; Benjamin Breyer, Jack McAninch, San Francisco, CA

**INTRODUCTION AND OBJECTIVES:** In long-segment penile urethral stricture disease, where a portion of the existing urethral plate must be completely resected, two-stage repairs are often advocated, since tubularization procedures have historically poor outcomes. In select patients, we have offered a unique single-stage repair that incorporates two distinct tissue sources relying on two separate blood supplies which we theorized would improve our results.

**METHODS:** Our prospective urethroplasty database was reviewed for patients where a dorsal onlay buccal mucosa graft was combined with a ventral onlay fasciocutaneous flap to circumferentially replace an entire diseased urethral segment. In all cases, both the flap and the graft were secured to the lateral edges of the corpus cavernosum and the diseased urethra was completely excised. Primary success was defined as an open urethra at > 1 year follow-up with no need for additional surgical intervention, secondary success as the need for ≤ 2 post-operative endoscopic procedures, and failures as need for repeat urethroplasty, urinary diversion or chronic catheterization.

**RESULTS:** There were 12 patients included, with stricture etiologies of trauma (5), urethral stent (2), hypospadias cripple (1) and idiopathic (4). The mean stricture length was  $9.75 \pm 4.6$  cm and mean

neourethral length was  $5.4 \pm 2.7$  cm. Stricture location was penile/bulbar in 10, and bulbar in 2. Primary success was achieved in 7(58%) patients at a mean follow-up time of  $3.73 \pm 2.9$  years. Median time to recurrence was 11.4 (0.9 to 33.1) months. Secondary success was achieved in 2 patients after 1 and 2 endoscopic procedures, for an overall success rate of 75%. Failure was associated with longer strictures (12.8 vs 8.7,  $p = 0.04$ ) than initial successes, but neourethral lengths were similar (6.2 v 5.1,  $p = 0.5$ ). Of the 3 (25%) that failed, one underwent repeat urethroplasty and 2 now require intermittent catheterization. No patients experienced repair breakdown or post-operative fistula formation.

**CONCLUSIONS:** Our initial outcomes were favorable using the combined tissue transfer technique for segmental urethral replacement with initial and secondary success rates similar to those reported for two stage repairs. This technique is not suitable for all patients as it requires healthy penile skin, but appears to be an effective single-stage option for long-segment repairs where a segment of urethra must be entirely replaced.

Source of Funding: none

## 86

### CONTEMPORARY MANAGEMENT OF RENAL TRAUMA: DIFFERENCES BETWEEN UROLOGISTS AND TRAUMA SURGEONS

Lawrence Yeung\*, Steven Brandes, Saint Louis, MO

**INTRODUCTION AND OBJECTIVES:** Controversy exists as to how renal trauma should be managed. The purpose of this study was to evaluate the contemporary practice patterns of urologists (US) and trauma surgeons (TS) regarding controversial topics in the management of renal trauma (RT).

**METHODS:** We conducted a national survey of all Society of Genitourinary Reconstructive Surgeons (GURS) members and a random sampling of American Association for the Surgery of Trauma (AAST) members between October and November 2010. The survey was disseminated via electronic mailings regarding management routines for various stages of blunt and penetrating RT.

**RESULTS:** The response rate was 33% ( $n = 117$  AAST, 39 GURS). 77% practice at level I trauma centers treating adults (95%) at academic teaching hospitals (84%). US obtain a "lay of the land" computed tomography (CT) scan prior to surgical exploration for penetrating RT more often than TS (77 vs. 18%,  $p < 0.001$ ). Surprisingly, 21% of responders do not use any tests to confirm the presence of another kidney prior to exploring an expanding retroperitoneal (RP) hematoma when a pre-operative CT is not done. When tests are done to confirm presence of another kidney, US prefer to use a "one-shot" intravenous pyelogram (82%) whereas TS prefer palpation (61%). TS do not obtain primary renal vascular control prior to opening the RP, whereas US do (21 vs. 71%,  $p < 0.001$ ). TS have a lower threshold for utilizing early angiography for the control of intravascular contrast extravasation compared to US (88 vs. 55%,  $p < 0.001$ ). TS over utilize ureteral stenting (50 vs. 24%,  $p < 0.001$ ) and underutilize observation and reimaging (40 vs. 64%,  $p < 0.001$ ) for isolated collecting system injuries compared to US. TS and US agree on conservative management of AAST grade 3 blunt RT. Surprisingly, both TS and US agree that a stable AAST grade 3 RT from gunshot wound should be managed by observation, even if the patient is explored for other abdominal injuries.

**CONCLUSIONS:** Trauma surgeons and Urologists can learn from each other, and there is an apparent lack of communication and differing treatment methods for renal trauma between the two disciplines – which often do not follow published guidelines (BJU Int 2004 93(7):937–54; Eur Urol 2005: 47(1):1–15). Moreover, that there are two camps with differing "community standards of practice" indicates that there is a desperate need for re-education, and for large scale, multi-institutional prospective studies on renal trauma to "standardize" the management of these injuries.

Source of Funding: None