

Editorial referring to the paper published in this issue on pp. 481–486 **TRAUMA AND RECONSTRUCTIVE UROLOGY**

## Salvage procedures in reconstructive urology

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This is an interesting evaluation of a group of extremely complicated patients, who developed non-reconstructible bladder outlets either due to injury, trauma or surgical misadventure. In my personal experience, this is one of the most difficult groups of patients to reconstruct and often requires heroic measures to salvage their quality of life and continence status. The authors are to be congratulated on their perseverance and well-planned care of this devastating patient group. As the study implies, this type of injury can occur from a variety of causations, including post-prostatectomy incontinence, bladder neck stenosis, neurogenic dysfunction, urethral tumor recurrence and patients with neobladders and post-tension-free vaginal taping (TVT) or colposuspension incontinence. Because this study includes both men and women, the authors have used a variety of techniques for purposes of closing the bladder neck. However, they have provided all patients with continent vesicostomy using an ileal segment that provides not only an augmentation but also a catheterizable stoma. Their results are emblematic of their technical skill and their intensive care of these individuals with an overall primary incontinence rate of 86.7.

Bladder neck closure, in and of itself, is a complicated procedure. The use of interposition grafts is a critical consideration, especially in women. Unfortunately, bladder neck closure can result in persistent

fistulization, which can be very problematic for subsequent management purposes. The authors are to be commended regarding their results with this as well. As the authors note, patients will require subsequent revisions for a variety of techniques and in fact, two of these series did demonstrate the need for secondary revisions. Complications are also common; both related to the use of bowel as well as the related issues of perineal breakdown and wound problems associated with bladder neck closure.

Due to mesh related complications in North America, bladder neck injury is being increasingly encountered. The primary efforts for these individuals are related to urethral reconstruction with autologous bladder neck slings, in an effort to salvage them. However, in some cases where mesh has been present for long periods, fixation and fibrosis in the peri-vesical and peri-bladder neck area results in substantive difficulties in management of these individuals. This can cause the ability to fall back to a bladder neck closure with an adequate pop off mechanism, in this case catheterizable stoma, to be a critical surgical technique. Again, I wish to personally congratulate the authors on the results and their care of this particularly bothered group of individuals.

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