Editorial referring to the paper published in this issue on pp. 93–97

TRAUMA AND RECONSTRUCTIVE UROLOGY

Management of iatrogenic, post–prostatectomy recto–urinary fistula – not a cut–and–dried debate. Does the best option exist?

Stanisław Wroński

Department of Urology, Skin & Tissue Bank, Jan Biziel Memorial University Hospital, Bydgoszcz, Poland

Adenocarcinoma of the prostate is the second most common non–skin malignancy in males. Worldwide screening programmes contribute to the growing volume of newly diagnosed, low–stage organ–confined cases and significantly reduced the number of advanced tumors. A growing body of evidence presented by a number of recently published papers and outcomes of large–scale trials extol and recommend "active surveillance" in selected low–stage cancers. Moreover, recently published data concerning progression of that tumor has revealed an indolent course in most cases [1, 2]. Despite strong basis of these evidences, radical treatment is still anticipated by patients and doctors alike. So far, either surgery or radiotherapy is the fundamental option for localised tumors. For our urological society, radical prostatectomy appears as the cutting edge in the management of prostate carcinoma in generally healthy patients with localized tumors and at least a 10–year life expectancy. Surgical treatment currently relies on four types of prostatectomy: perineal, retropubic, laparoscopic, and robot–assisted [2]. The qualification criteria for all types are similar. On the other hand, different types of radiotherapy prevail in many countries. A plethora of literature has been devoted to review all pros and cons of above types of radical prostatectomy. Numerous studies did not reveal any significant differences in outcomes after all approaches and the debate whether any technique possesses superiority over the other remains rhetorical [2, 3, 4]. All the techniques have yielded equivalent effectiveness rates. Yet, complications are liable to occur. Certainly, each type of surgery entails an inevitable, although small, number of serious complications. One of the most troublesome late surgical complications are after–effects of rectal injury. Intraoperative inadvertent injury of the rectal wall occurs in 1.5–11% of cases, regardless of the type of prostatectomy, though somewhat more often after perineal access [3, 4]. It may resolve without further consequences if secured immediately. Sometimes (in 1.5–3.6%), a rectal laceration develops toward a fistula [5]. That abnormality may run between the anterior rectal wall and bladder base or urethra. Our personal (Dept. of Urology in Bydgoszcz) experience based upon a dozen or so cases shows that the vast majority of fistula tracts connect the rectum and: a) posterior urethra next to the anastomosis, b) just right in the anastomosis or c) right next to anastomosis in the bladder neck. Though uncommon and not life–threatening, any type of post–prostatectomy recto–urinary fistula always has a devastating impact on quality of life, compromising even the most successful results of surgery as well. It is obvious and intelligible. Alas, here we are not in the right place nor time to ponder over the timing of fistulae repair; as in on the debate over early or delayed procedure and its conservative or surgical treatment. As experienced at our institution (and many others), the best results were achieved by deferred fistulae repair, early temporary colostomy with prolonged urinary drainage for purge of inflammatory and necrotic debris. Let's leave that issue aside (for now). It is enough to say that surgical approaches to urinary–rectal fistula include abdominal, perineal, transanal or mixed procedures. Its specific anatomic location makes any treatment challenging and deserves individualized treatment in each case. A few dozen different techniques potentially suitable for fistula repair have been described so far [6]. What does this tell us ?. Simply, the perfect one (…or two, maybe) does not exist. That's why authors of the paper entitled: "Treatment of urethro–rectal fistulas caused by radical prostatectomy – two surgical techniques" deserved kudos [1]. Please read it when leafing the latest edition of the CEJU. The authors nicely pre-

10.5173/ceju.2014.01.art22

sented their surgical skills resulting in complete effectiveness of the treatment they had taken up – it is indisputable. But, they prudently made it clear that: "Effectiveness of the procedure is hard to asses on the basis of so few patients". The presented article is important not only as a presentation of surgical skills and/or effectiveness of any given procedure, but it also brings up an unassuming issue of complications in surgery and ways of resolving them. It is a veritable touch–and–go business. Discussion on the treatment of nasty complications recedes into the background as it is not a hot topic. Very often such patients drive from pillar to post. Do you want to deal with iatrogenic complications ? – prepare yourself to swallow a bitter pill. I am making a rough mention of (my) sparse failed procedures. Successful ones – even multiple – will be lost in the mists of time. Hopefully, the presented 100% success rate achieved for the described patients will translate into similar efficacy in much larger group. Presentation of the use of interposed, well vascularised muscular flaps, such as the gracilis muscle, is a great advantage of the discussed paper. This is an excellent description of a promising method of fistulae repair.

If I may pass some remarks (not putting a spoon of tar in a barrel of honey, of course) a few issues have been left unsaid:

1. Two described patients with recurrent fistula reflect the fact that primary repair, soon after prostatectomy (a few days, as authors stated) particularly without colostomy is a risky gamble. Believe me, I have tried and I became disappointed with it – once bitten, twice shy.
2. The very important issue of the extent of fistula openings at each case has been abandoned by the authors.
3. Next, we do not know the stage of the disease just before prostatectomy and final histopathology.
4. Next again, it would be informative for the readers to know the current PSA level of the described patients.

At the end of those considerations, I would like to emphasise my sincere encouragement to engross that article. Anyhow, I was absorbed in this paper.

References

1. Polom W, Krajka K, Fudalewski T, Matuszewski M. Treatment of urethrorectal fistulas caused by radical prostatectomy – two surgical techniques. Cent European J Urol. 2014; 67: 100-104.
2. Johansson JE, Andrén O, Andersson SO, Dickman PW, Holmberg L, Magnuson A, Adami HO.: Natural history of early, localized prostate cancer. JAMA. 2004; 291: 2713–2719.
3. Wroński S. Radical perineal prostatectomy – the contemporary resurgence of a genuinely minimally invasive procedure: procedure outline. Comparison of the advantages, disadvantages, and outcomes of different surgical techniques of treating organ–confined prostate cancer. A literature review with special focus on perineal prostatectomy. Cent European J Urol. 2012; 65: 188–194.
4. deArruda HO, Cury J, Ortiz V, Srougi M. Rectal injury in radical perineal prostatectomy. Tumori 2007; 93: 532–535.
5. Yee DS, Ornstein DK. Repair of rectal injury during robotic–assisted laparoscopic prostatectomy. Urology. 2008; 72: 428–431.
6. Eden CG: Minimal access radical prostatectomy: how is it shaping up? BJU Int 2008; 101: 791–792.
7. Crippa A, Dall'oglio MF, Nesrallah LJ, Hasegawa E, Antunes AA, Srougi M. The York–Mason technique for recto–urethral fistulas. Clinics. 2007; 62: 699–704. ■

Correspondence
Stanisław Wroński, M.D., FEBU
wrona@ozzl.org.pl