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BLADDER AUGMENTATION CYSTOPLASTY FOR REFRACTORY DETRUSOR INSTABILITY

Synopsis of Video

This video tape shows a comprehensive approach to bladder augmentation cystoplasty for patients with refractory severe detrusor instability.

The procedure is carried out under general anesthesia. An infraumbilical abdominal incision is made and the reptropubic area is gentle dissected, avoinding peritoneal opening. The bladder is filled with saline through an urethral catheter, to ease it's dissection. A small peritoneal incision is performed and the terminal ileum is identified. Only the segment necessary for identification of the proper ileal area is exposed. Two 3 zero silk sutures are used to select a 30 cm segment of the terminal ileum, far 20 cm from the ileumcecal valve. The isolated ileum is checked to verify if it easily adapts to the vesical dome. Then, the mesenterium is carefuly dissected after the study of the vascular supply to the isolated ileum. After verify the vitality of ileal stumps, a mechanic intestinal anastomosis is made. The isolated ileum is washed with a polyvinil pirrolidone antiseptic solution and it´s anti-mesenteric border is carefully opened permiting its reconfiguration as an U shaped plate, using tight ininterrupted 3 zero poliglactine sutures. Subsequently, the bladder is transversally opened from one side to another in order to create a posterior vesical flap, allowing to a wide anastomosis. The posterior anastomosis is done using ininterrupted 3 zero poliglactie stitches. The anterior anastomosis is begun by placing a repair from the middle of the anterior bladder wall to the vertix of the reconfigurated ileum. Further, the borders are sutured with 3 zero popliglactine threads, starting from their extremities. Before the end of the suture a 18 French cystostomy catheter is placed to help the post-operative urinary drainage. At the end of the suture the augmentated bladder is filled with saline to verify if any significant leakage occurs. The retropubic space is drained with a Penrose and the abdominal wall is sutured in an usual manner.

Although the surgical treatment of detrusor instability remains an exceptional situation, this pocedure can be the best and even the unique alternative for a selective group of patients who have previously failed after drug, physiotherapic and behavioural conservative measures.