



SURGICAL TECHNIQUE

Treatment of long anterior urethral stricture associated to lichen sclerosus[☆]J.C. Angulo^{a,b,*}, I. Arance^a, C. Esquinas^a, D. Nikolavsky^c, N. Martins^d, F. Martins^d^a Departamento Clínico, Facultad de Ciencias Biomédicas y de la Salud, Universidad Europea de Madrid, Laureate Universities, Madrid, Spain^b Servicio de Urología, Hospital Universitario de Getafe, Madrid, Spain^c Departamento de Urología, State University of New York Upstate Medical University, Syracuse, NY, USA^d Departamento de Urología, Universidad de Lisboa, Hospital de Santa Maria, Lisboa, Portugal

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KEYWORDS

Lichen sclerosus;
Urethral stricture;
Urethroplasty;
Buccal mucosa

Abstract

Introduction: Panurethral stricture associated with lichen sclerosus is a therapeutic challenge. We present the analysis of our results using two urethroplasty techniques based on oral mucosa graft.

Material and method: Retrospective study in patients with long anterior urethral stricture (>8 cm) associated with lichen sclerosus. Patients received urethroplasty with oral mucosa graft technique according Kulkarni ($n=25$) or two-step Johanson–Bracka urethroplasty ($n=15$). Demographics, operative time, complications (Clavien–Dindo), hospital stay, days with catheter, EAV postoperative pain, failure rate, need for retreatment and functional data including IPSS, QoL, Qmax, post void residual (PVR) are evaluated.

Results: In all cases there was involvement of glandular and penile urethra, and in 75% of bulbar urethra. A single graft was used in 22.5%, two in 72.5% and three in 5%. Patients treated at a single step were younger ($p=0.007$). Although the length of the stenosis was equivalent in both techniques ($p=0.96$), relapse and complication rates were higher in two-step surgery ($p=0.05$ and $p=0.03$; respectively) and so was operative time ($p<0.0001$) and overall stay ($p=0.0002$). There were no differences in preoperative IPSS, QoL, Qmax or PVR, neither in postoperative values of IPSS or Qmax; but there was a difference in QoL ($p=0.006$) and PVR ($p=0.03$) favoring single-step urethroplasty. VAS pain on postoperative day 1 was also lower in Kulkarni urethroplasty than in the first step of Johanson–Bracka technique ($p<0.0001$).

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PALABRAS CLAVE

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Estenosis de uretra;
Uretroplastia;
Mucosa bucal

Conclusions: In patients with lichen sclerosus and long anterior urethral stricture Kulkarni urethroplasty provides more efficient and better patient reported outcomes than Johanson-Bracka urethroplasty. It also prevents cosmetic, sexual and voiding temporary deterioration inherent to 2-step surgery.

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Tratamiento de la estenosis larga de uretra anterior asociada a liquen escleroso

Resumen

Introducción: La estenosis panuretral asociada a liquen escleroso supone un reto terapéutico. Presentamos el análisis de nuestros resultados empleando 2 técnicas de uretroplastia basadas en injerto de mucosa oral.

Material y método: Estudio retrospectivo en pacientes con estenosis larga de uretra anterior (>8 cm) asociada a liquen escleroso. Los pacientes recibieron uretroplastia con injerto de mucosa oral según técnica de Kulkarni (n = 25) o uretroplastia en 2 tiempos tipo Bracka-Johanson (n = 15). Se evalúan datos demográficos, tiempo operatorio, complicaciones (Clavien-Dindo), estancia hospitalaria, EAV de dolor postoperatorio, tasa de fracaso, necesidad de retratamiento y datos funcionales que incluyen IPSS, CdV y Qmáx, residuo posmiccional (RPM).

Resultados: En todos los casos hubo afectación glandular y peneana y en el 75% de uretra bulbar. En el 22,5% se empleó un solo injerto, en el 72,5% 2 y en el 5% 3. Los pacientes tratados en un solo tiempo fueron más jóvenes (p = 0,007). A pesar de que la longitud de la estenosis fue equivalente en ambas técnicas (p = 0,96), la tasa de recidiva y de complicaciones fue superior en 2 tiempos (p = 0,05 y p = 0,03; respectivamente), así como el tiempo operatorio (p < 0,0001) y la estancia global (p = 0,0002). No hubo diferencias en IPSS, CdV, Qmáx o RPM preoperatorios, ni tampoco en los valores postoperatorios de IPSS o Qmáx; pero sí en CdV (p = 0,006) y RPM (p = 0,03) a favor de uretroplastia en un tiempo. La EAV de dolor en el 1.º día postoperatorio fue también menor en la uretroplastia de Kulkarni que en el primer tiempo de Johanson-Bracka (p < 0,0001).

Conclusiones: En pacientes con liquen escleroso y estenosis larga de uretra anterior la uretroplastia de Kulkarni proporciona resultados operatorios más eficientes y mejor valorados por el paciente que la uretroplastia de Johanson-Bracka. Además, evita el deterioro temporal cosmético, sexual y miccional inherente a la cirugía en 2 tiempos.

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Introduction

Lichen sclerosus (LS) is one of the growing causes of urethral stricture. The etiology of the process is unknown, although it seems quite likely that is an autoimmune mechanism related to chronic irritation secondary to urinary extravasation into urethra spongy body.¹ The detection of autoantibodies to extracellular matrix protein 1 in a high percentage of patients² and markers of oxidative stress³ possibly explain sclerosis and carcinogenesis associated with this entity, which seems more likely in Hispanic males.⁴ The glans and the foreskin is affected in most patients, the urethral meatus is affected in approximately 40% and urethra around 20%,⁵ although recent studies suggest that urethral involvement may be more frequent.⁶ Progression of the disease leads to phimosis and urethral stricture, which is often complex. It represents one of the most common causes of urethral panstenosis, especially in developed countries.^{7,8}

The surgical management of this entity ranges from simple circumcision, with or without meatotomy, to extensive urethral and genital reconstruction. Surgical technics to treat urethral stricture that employs fasciocutaneous flaps

are doomed to a high failure rate^{9,10} to the extent that the use of skin (genital and non-genital) is considered contraindicated in repairing urethral strictures due to LS.¹¹ Buccal mucosal-free grafts (BMFG) has positioned as the most suitable material for such repairs, using one-stage or multistage techniques.^{5,6,12-14}

The principle of replacement of the entire urethral segment affected by LS led to the abandonment of the primary cutaneous grafting techniques and enhanced the use of surgeries in two or more stages. Those stages are based on the replacement of the diseased urethra by large BMFG and subsequent delayed closure of the rebuilt urethral plate.⁵ More recently, the Kulkarni technique has gained progressive popularity. This technique is based on the use of BMFG of dorso-lateral placement, which increases urethral light, preserving the vascularization of the anterior urethra and prolonging urethroplasty up to the bulbar urethra. It also preserves the bulbospongiosus muscle, the central tendon of the perineum and perineal innervation.¹³ Patients with panurethral stricture due to LS can be treated with one-stage urethroplasty technique, can undergo great cosmetic improvement and do not have the sexual and urinary

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