Entérocystoplastie d’agrandissement et robotique

Christian Saussine

Service d’urologie

Hôpitaux Universitaires de Strasbourg

Conflits d’intérêt

- Aucun

Le principe

- Recréer un réservoir vésical à basse pression
  - Rendre inefficace les contractions involontaires du détrusor
- Recréer un réservoir vésical de bonne capacité

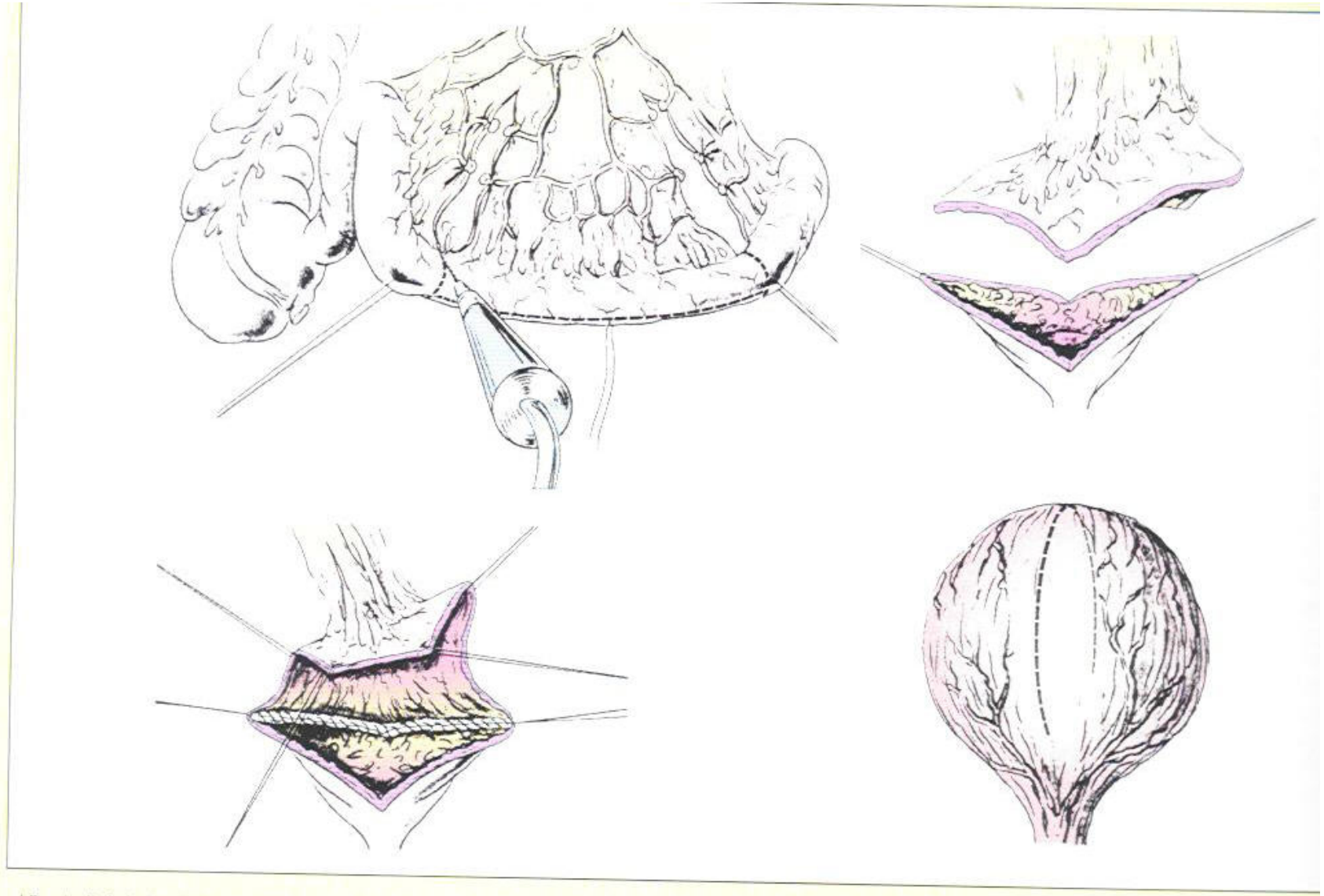
Les indications

- 3è ligne de traitement de l'hyperactivité du détrusor neurologique ou idiopathique réfractaire aux 2 premières lignes
- L'hypertonie vésicale réfractaire/ les troubles de compliance

- Associée à une dérivation continente
- Associée à une cystectomie supratrigonale

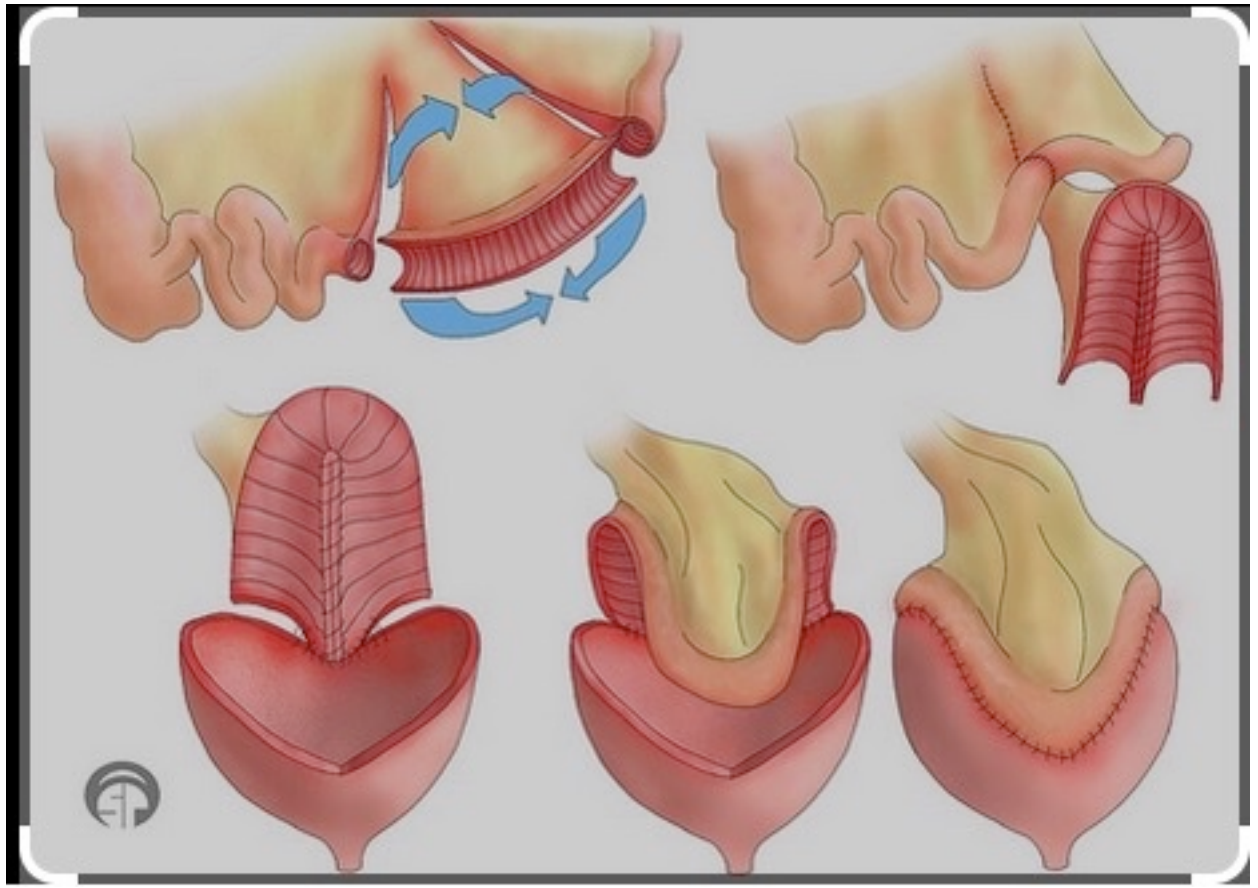
- Nécessité de réaliser des autosondages

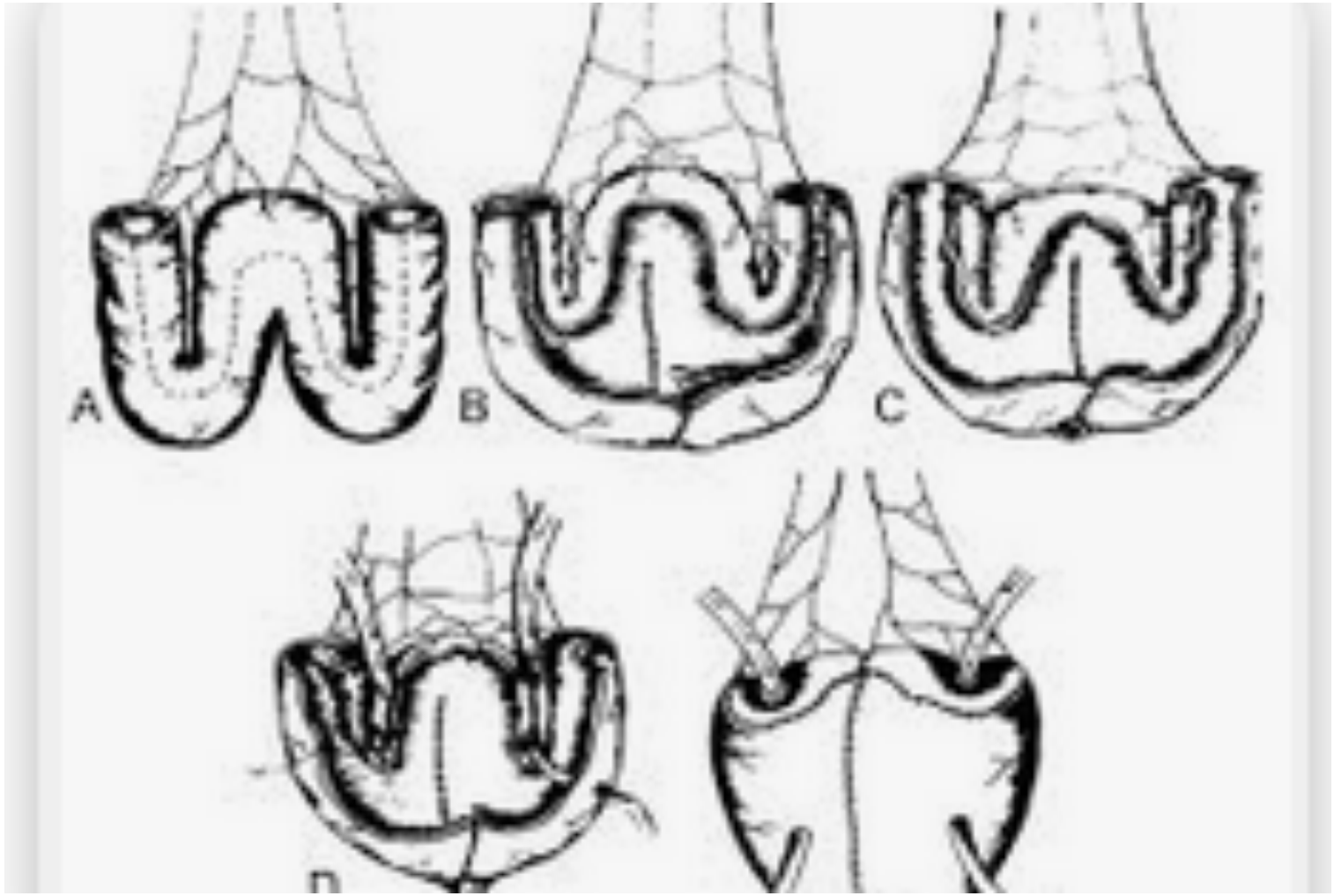
L’ENTEROCYSTOPLASTIE



(d'après B. Lobel et F. Guille - Entérocystoplastie d'agrandissement. Encycl. Med. Chir. (Paris, France) Techniques chirurgicales. Urologie-Gynécologie. 41207. 6-1989. 10p

L’entérocystoplastie





L’entérocystoplastie

> Eur Urol. 2021 Jun;79(6):858-865. doi: 10.1016/j.eururo.2020.08.005. Epub 2020 Oct 2.

Robot-assisted Supratrigonal Cystectomy and Augmentation Cystoplasty with Totally Intracorporeal Reconstruction in Neurourological Patients: Technique Description and Preliminary Results

Nuno Grilo [1], Emmanuel Chartier-Kastler [2], Pietro Grande [2], François Crettenand [3], Jérôme Parra [2], Véronique Phé [2]

- all patients undergoing RASCAC, as treatment for refractory neurogenic detrusor overactivity, from August 2016 to April 2018.
- Ten patients were identified. No conversion to open surgery was needed.
- The median operative time was 250 (interquartile range 210-268) min,
- the median estimated blood loss was 75 (50-255) ml,
- the median hospitalization time was 12 (10.5-13) d.
- The 30-d major complication rate was 10%. Two patients presented a late urinary fistula; in one of the cases, surgical revision was needed. In both cases, low compliance to intermittent self-catheterization was identified.
- At 1-yr follow-up, functional and urodynamic outcomes were excellent.

Comparative Study > Urology. 2016 Nov:97:172-178. doi: 10.1016/j.urology.2016.06.053.
Epub 2016 Jul 18.

Comparative Outcomes and Perioperative Complications of Robotic Vs Open Cystoplasty and Complex Reconstructions

Andrew J Cohen [1], Katie Brodie [2], Prithvi Murthy [3], Duncan T Wilcox [2], Mohan S Gundeti [3]

- Patients undergoing augmentation ileocystoplasty open vs robotically between 2008 and 2014 at 2 centers
- 17 (open) and 15 (robotic) patients with median follow-up of 45 and 46 months,
- Median operative time (incision to closure) was longer in the robotic cohort (265 minutes vs 623 minutes, P < .001).
- Median length of stay (7 days vs 6 days, P = .335), time to diet (4 days vs 4 days, P = .125), and mean intravenous morphine equivalents/kg (1.23 mg/kg vs 0.56 mg/kg, P = .091) were comparable between groups for open and robotic, respectively.
- There were 4/17 (23.5%) of the open cohort who had an epidural for an average of 93 hours. All patients had stable or improved hydronephrosis postoperatively. Major reoperations, such as for bowel obstruction, were required in 2/17 (11.7%) in the open group and none in the robotic cohort. Minor stomal complications requiring skin-level revision or endoscopic procedure occurred in 4/17 (23.5%) in the robotic cohort and 2 (11.7%) in the open group.

Avantages subjectifs Robot Vs open

- Délabrement pariétal faible
  - Retour à domicile plus rapide
  - Peu de risque d'éventration
- Moindre fatigue du chirurgien
- Utilisation systématique de l'agrafage mécanique (prélèvement intestinal)

- Qualité identique des sutures manuelles (réalisation de la plastie) mais réalisation plus facile
- Technique réalisée identique

Conclusion

- Robotique est adaptée à ce type de chirurgie avec nombreuses sutures
- La généralisation des robots devrait faire disparaitre les autres voies d'abord pour l'entérocystoplastie qui n'est pas pratiquée par tous les urologues.