PE70 Ejaculatory-sparing robot-assisted “Pure” adenomectomy for large prostate adenoma even with median lobe

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Introduction & Objectives: Recently, robotic assisted simple prostatectomy (RASP) has become a treatment option for Prostatic Benign Hyperplasia (BPH). In order to reduce the sequaele of this surgery, we use a “urethral-sparing approach” during the dissection of the adenoma with the aim to spare the ejaculatory function. We present the results of 50 patients underwent this approach.

Materials & Methods: From August 2017, patients with indications to BPH surgery, prostate volume >100cc were enrolled. Demographic, perioperative variables, functional results were analysed. Early complications (<30 days from surgery) were recorded and classified according to Clavien Dindo System. The “trifecta outcome” (combination of International Prostate Symptom Score <8, Qmax > 15 mL/s, and no perioperative complications) was evaluated up to 1 year of follow-up. Surgical technique: A transversal, anterolateral incision is made halfway between the Dorsal Venous Complex (DVC) and the bladder neck on the prostatic capsule. The cleavage plane between the surgical capsule and the adenoma is identified anteriorly and dissected at the level of prostate apex bilaterally. Once the left lobe is mobilized a median longitudinal incision is made at the level of anterior commissure. The urethra is medialized by suction device and dissected from the left lobe. At the end the left lobe is removed. The procedure is repeated for the right lobe. Thus the urethra is spared inside the prostatic lodge. Prostatic capsule is then barbed sutured. In case of median lobe a median transversal incision is made at the level of the anterior side of the bladder. Two incisions of the bladder and prostatic urethral mucosa are made to expose the third lobe.

Results: 50 patients were enrolled: mean age was 68 years, mean prostate volume was 163 cc, 11 patients had median lobe. Mean IPSS score was 19 and mean Qmax was 11.7 ml/sec. 28 patients had valid ejaculation before surgery. All the patients underwent Pure adenomectomy: mean operative time was 111 minutes; blood losses were 350mL. In 3 (8%) patients the urethra was violated during the intervention and required a dedicated suture. Catheterization time and hospital stay were 5 and 6 days, respectively. No complications were recorded during follow up and the “trifecta outcome” was achieved in all patients at 30 days postoperatively and was maintained up to the end of follow-up. At the end of follow-up period, a normal ejaculation was maintained in 21/28 (75%) of patients. Moreover, the spermiograms collected at 6^{th} month of follow-up revealed a mean volume of seminal fluid of 3 mL (SD: 2.6) with a mean number of spermatozoa\mL of 14 millions\mL (SD: 3.6).

Conclusions: Our robot-assisted adenomectomy seems to be safe in the treatment of large prostatic adenoma even in case of median lobe; moreover it does not seem to affect ejaculation.