Letters to the Editor

Concerns About the Use of a Free Graft During York-Mason Intervention

SIR:

I would like to congratulate McKibben et al[1] on their recent paper, focused on the York-Mason intervention in the treatment of iatrogenic rectourinary fistulas. The analysis of the functional results of their series demonstrated that this approach is safe and efficacious in treating this devastating complication of prostatic surgery. Interestingly, they introduced an adjunctive maneuvre modifying the original York-Mason technique: the interposition of a local free graft of subcutaneous fat between the urothelial and the rectal tissues. The authors underlined that this procedure could fill the defect after the removal of the fistula and the necrotic surrounding tissue.

Starting from the "dogma" that the interposition of some structure between 2 sutures in treating a fistula is an "ideal" solution to reduce the risk of a recurrence of fistula, the solution proposed by the above authors could be extremely useful.

My personal concerns about this surgical procedure are due to the specific characteristics of the tissues involved in such a specific situation as this:[2] indeed, as underlined by McKibben et al in the paper, we do not know the exact rate of graft which is really "vital" after the procedure and the well-known paucity of vasculature at this level does not look good.

Although this adjunctive maneuvre seems to be safe and fast, we cannot be sure that the reported "minimal" percentage (40%) of flatus/faecal incontinence after the intervention is not related to only the graft interposition: in fact, starting from my specific experience performing this intervention, I believe that the crucial moments in the York-Mason intervention are first the anatomical juxtaposition of the urethral and rectal layers, and then the meticulous reapproximation of the muscular sphincteric layers (in the reconstruction time). For this reason, the interposition of free fat tissue could be counter-productive if the nonvital graft transforms into necrotic tissue that reabsorbs itself, producing only a lack of substance, resulting in a dysmorphia of the sphincter with a consequent risk of nonperfect competence of the fecal sphincter.

I believe that, due to extreme complexity of the anatomy at this level, a "dogma" in the reconstructive surgery should be repairing the anatomy avoiding any kind of geometrical distortion.

References

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2. Dal Moro F, Secco S, Valotto C, Mancini M, Beltrami P, Zattoni F. Twenty-year experience with surgical management of recto-urinary fistulas by posterior sagittal transrectal approach (York-Mason). *Surgery*. 2011;150:975–979.

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Reply by the Authors Re: Dal Moro: Concerns About the Use Of A Free Graft During York-Mason Intervention (Urology 2019;123:298)

TO THE EDITOR:

While we recognize the thoughtful nature of this critique regarding the use of interposing fat grafts during the modified York-Mason procedure, we disagree with the concept of aberrant functionality or healing results. On the contrary, urinary and fecal streams are individually repaired to completion—the fat graft then is placed between the watertight suture lines as a finalizing barrier. We reject the notion that interposing fat in this manner creates anatomic distortion of any physiological significance.

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