

EPIDEMIOLOGICAL DESCRIPTION AND MANAGEMENT OUTCOMES OF BENIGN URETEROENTERIC STRICTURE AFTER RADICAL CYSTECTOMY: A SINGLE-CENTRE EXPERIE

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Introduction



Ureteroenteric anastomosis stricture (UES) after Cystectomy appears between 3-10%.



Open ureteral reimplantation is the gold standard treatment




Endoscopic approach has a lower success rate with less complications



Predictors of treatment failure are poorly defined.



Our objectives were to characterize the UES and outcomes after its treatment and identify risk factors for treatment failure and UES recurrence.



Materials and Methods

We performed a retrospective review of 2520 patients who underwent RC in our centre, between May 1990 and October 2018.

We collected data on UES with intention to treat: Baseline clinicopathologic characteristics, details of UES, primary treatment, and perioperative outcomes were analysed.

Predictors for stricture recurrence and treatment failure were assessed by univariable testing and multivariable stepwise regression

RESULTS

We found a total of 111 patients with UES after RC with intention to treat on the analysed period

1. General characteristics

	N	%
Gender		
Female	11	9.9
Male	100	90.1
Reason for cystectomy		
Others	8	7.2
Tumor	103	92.8
Urinary Diversion Type		
Studer	22	19.8
Others	8	7.2
Ileal conduct	81	73
Uretero-enteric anastomosis Type		
Bricker	31	28.7
Otro	4	3.7
Wallace	73	67.6
Cystectomy approach		
Open	88	80.7
Laparoscopic	9	8.3
Robotic	12	11

	Mean	SD	Median	Min	Max
Age (years)	67,8	11	70	14	87
Follow up time (months)	69	57.6	52.8	3	342.2

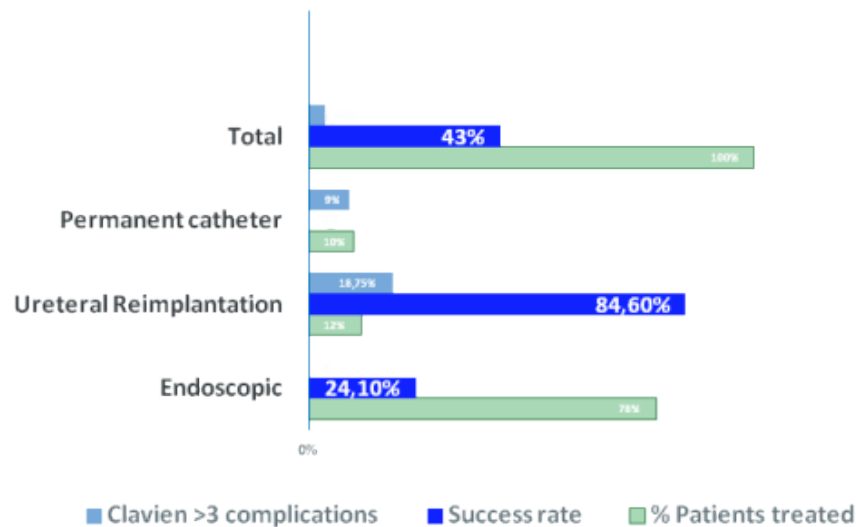
	Mean	SD	Median	Min	Max
Time to diagnosis (months)	43.9	76	8.9	0.3	399
Stenosis length (cm)	1,4	1,3	1	0,5	7

2. Characteristics of uretero-enteric stenosis

	N	%
Side		
Bilateral	30	27
Right	20	18
Left	61	55
Radiological aspect of stenosis		
No image available	13	11.7
Duck beak or sharpening	66	59.5
Concave or flat	32	28.8
Emergency Nephrostomy		
No	31	27.9
Yes	80	72.1
Clinical Presentation		
Asymptomatic	29	26
Symptomatic	82	74

RESULTS

3. Primary treatment of uretero-enteric stenosis



4. Multivariate logistic regression model for primary endoscopic treatment failure: not possible to perform.

	Multivariate			
	OR	IC95% inf	IC95% sup	Pvalue
Bilateral (ref)	1			
Right side	4.71	0.85	30.81	0,07
Left side	3.67	1	16.81	0,06
Stenosis lenght	1.09	0.73	1.64	0.65
Radiological aspect of stenosis: Concave or flat (ref)	1			
Radiological aspect of stenosis: duck beak or sharpening	0.12	0.03	0.4	<0.001

4. Multivariate logistic regression model for primary endoscopic treatment failure: 12 month recurrence

	Univariate				Multivariate			
	OR	IC95% inf	IC95% sup	Pvalue	OR	IC95% inf	IC95% sup	Pvalue
Bilateral (ref.)	1				1			
Right	0,3	0,06	1,21	0,1	0.16	0.03	0.75	0,03
Left	0,5	0,17	1,42	0,2	0.32	0.09	1.01	0,06
Stenosis length	1,04	0,72	1,47	0.83				
Radiological aspect of stenosis: Concave or flat (ref)								
Radiological aspect of stenosis: duck beak or sharpening	2,48	0,92	7,26	0,08	4.04	1.33	14.51	0,02
Time to diagnosis	1	0,99	1,01	0,9				
Type of surgery: open (ref)	1							
Type of surgery: laparoscopic	3,22	0,58	24,56	0,2				
Type of surgery: robotic	1,15	0,31	4,03	0,83				
Urinary diversion type : Studer (ref)	1							
Urinary diversion type: others	0	NA	NA	0,99				
Urinary diversion type: Ileal conduct	1,76	0,56	6,2	0,35				
Uretero-ileal Anastomosis type: _bricker (ref)	1							
Uretero-ileal Anastomosis type: other	0	NA	NA	0,99				
Uretero-ileal Anastomosis type: Wallace	1,27	0,46	3,65	0,65				
Gender Male	0,23	0,01	1,89	0,21				
Age	1,02	0,98	1,07	0,34				
BMI	0,97	0,86	1,08	0,57				
ASA 2 (ref)	1							
ASA 3	0,94	0,38	2,36	0.89				
ASA 4	0	NA	NA	0.99				

Conclusions



ENDOSCOPIC APPROACH IS A SAFE ALTERNATIVE TREATMENT OF UES WITH ACCEPTABLE RESULTS AND VERY LOW COMORBID



ENDOSCOPIC TREATMENT DOES NOT AFFECT SUBSEQUENT RESULTS OF OPEN OR LAPAROSCOPIC SURGICAL CORRECTION.



IDENTIFICATION OF RISK FACTORS OF ENDOSCOPIC TREATMENT FAILURE COULD HELP TO PROVIDE BETTER PATIENT SELECTION IN ORDER TO IMPROVE SUCCESS RATE.

