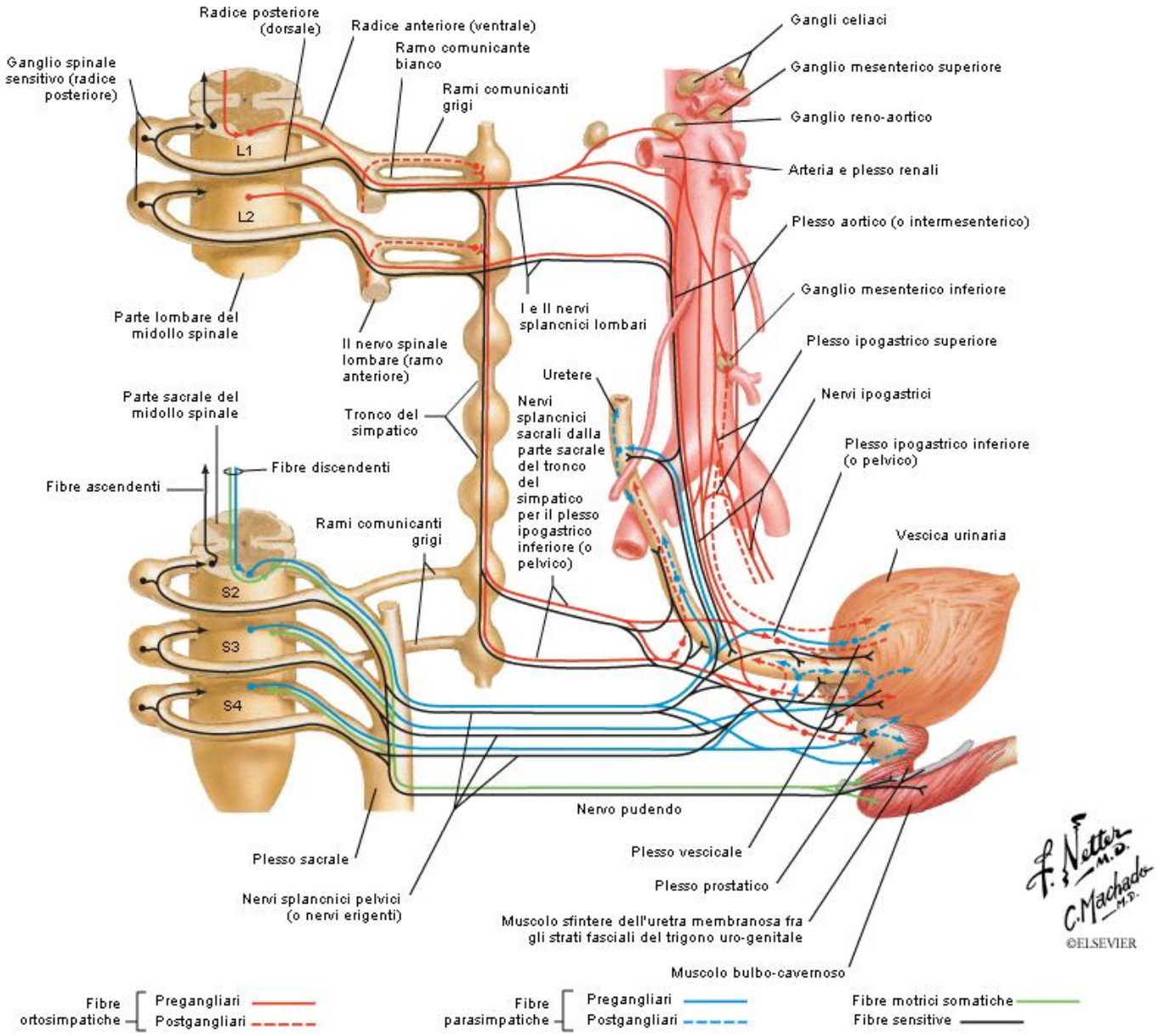
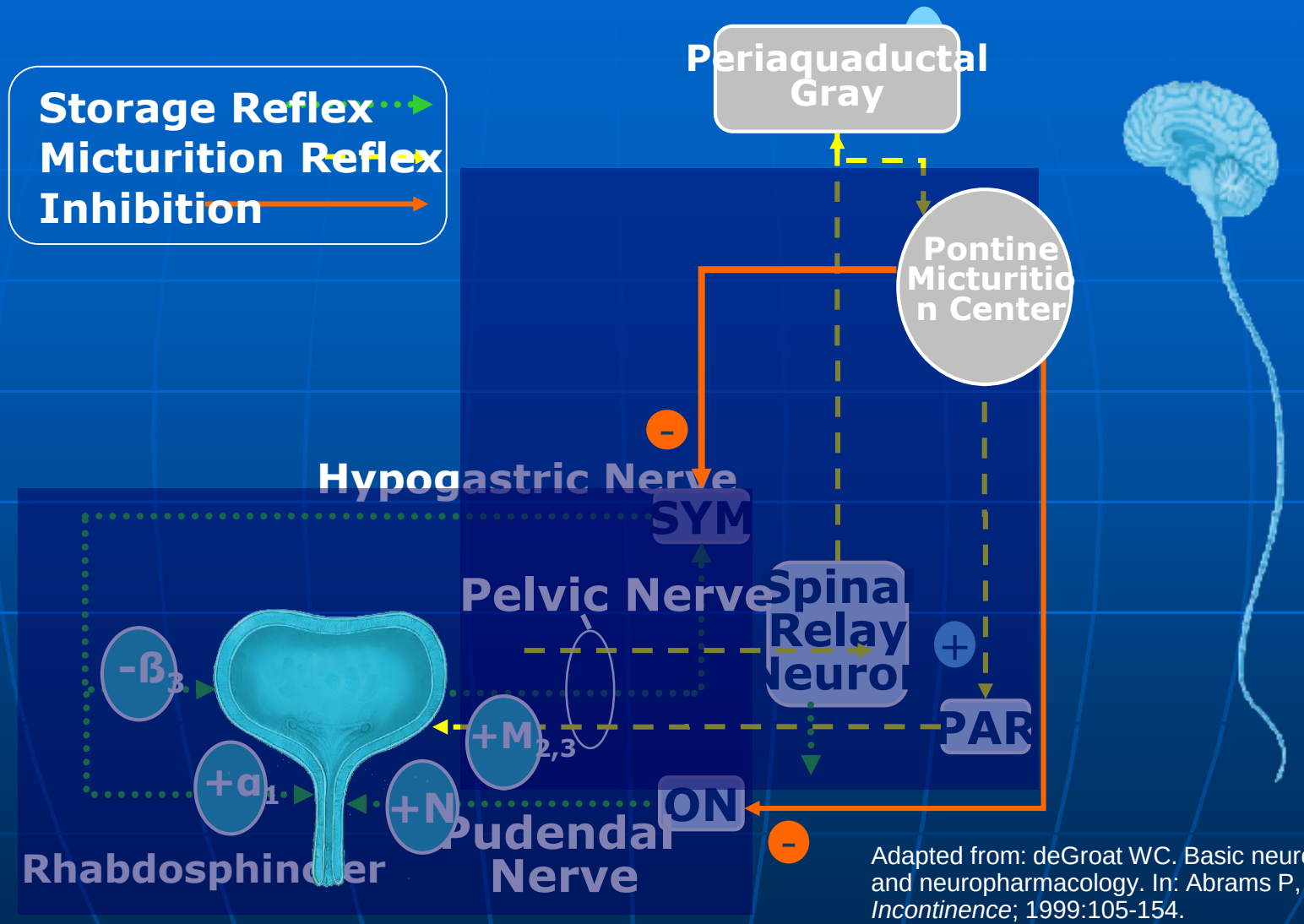
INCONTINENZA E RITENZIONE; COSA FARE E COSA FAREMO

Dott. A. Tagliabue – U.O. Urologia ASST Ovest milanese – Osp. di Magenta

Innervazione della vescica urinaria e della parte inferiore dell'uretere, schema





Adapted from: deGroat WC. Basic neurophysiology and neuropharmacology. In: Abrams P, et al, eds. *Incontinence*; 1999:105-154.

Incontinenza urinaria

. Da deficit sfinterico
. Da attività peristaltica dell’ansa ileale
. Da overflow

- Incontinenza urinaria diurna
- Incontinenza urinaria notturna

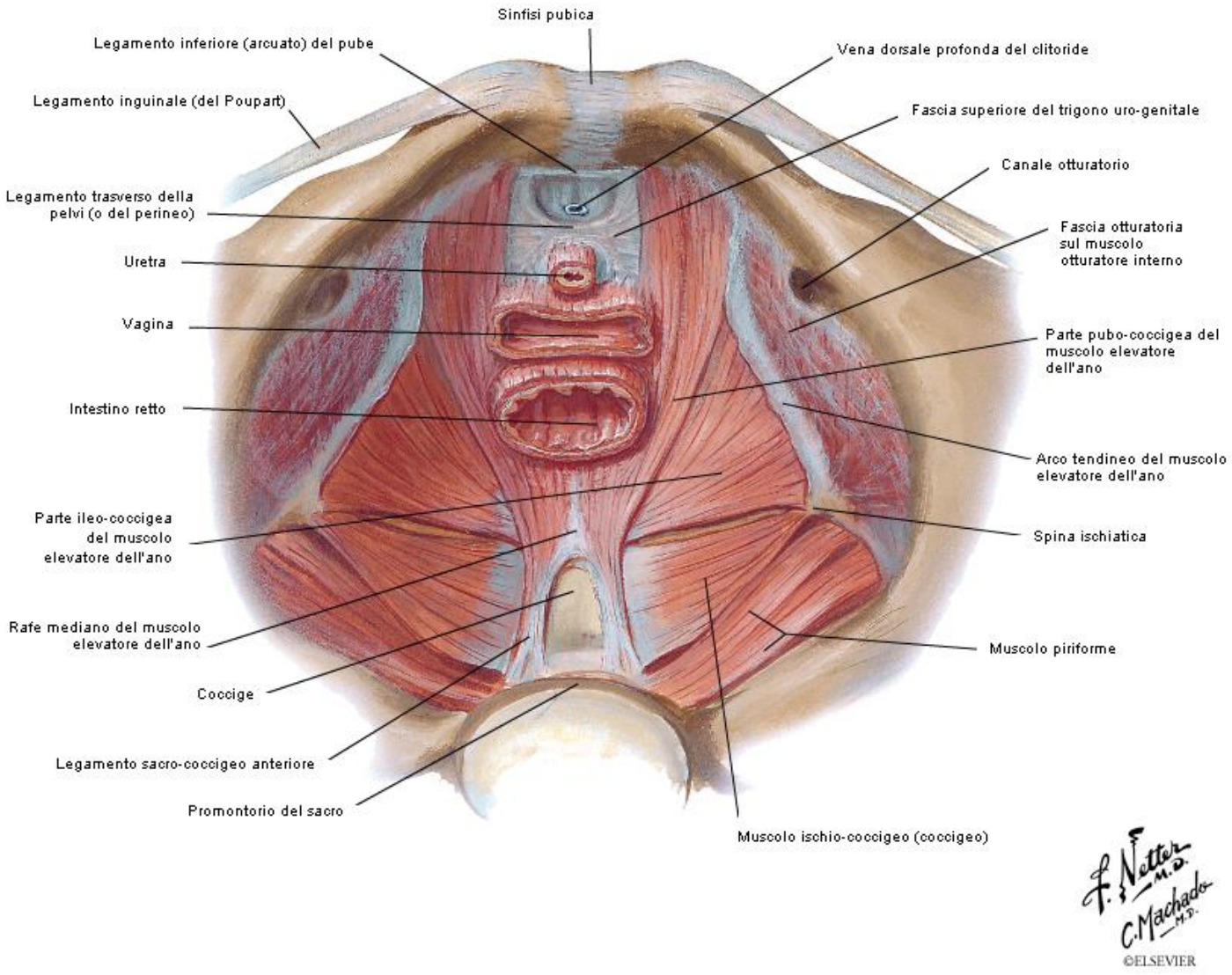
IPERCONTINENZA

. Prolasso posteriore
. Modifica dell’angolo neoserbatoio-uretrale
. Mancato rilasciamento del piano perineale durante minzione
. Associata o meno ad incontinenza

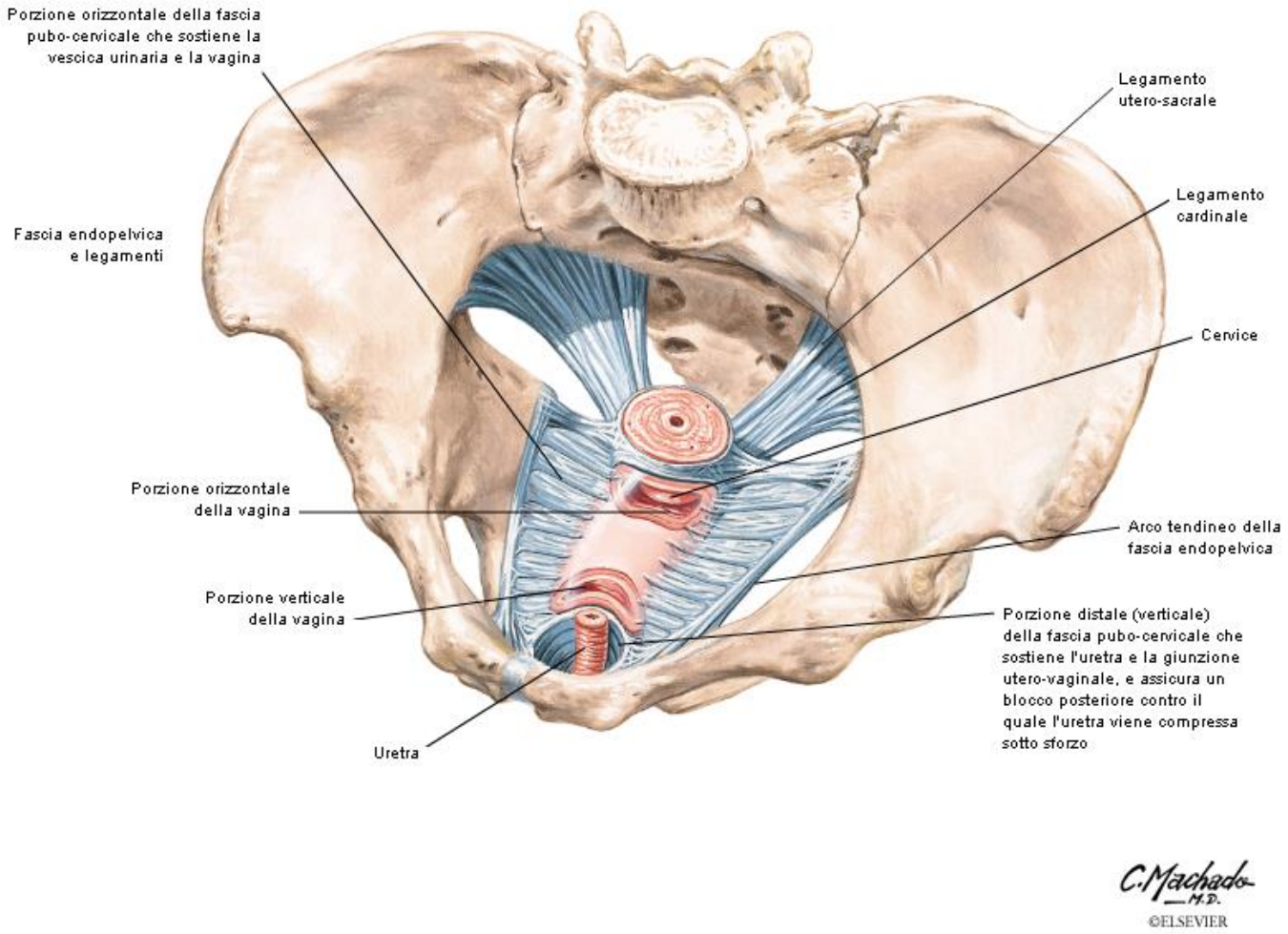
. ritenzioniste già prima dell’intervento
. aumento della capacità del neoserbatoio
. stenosi dell’anastomosi tra neo vescica ed uretra

Diaframma pelvico nella femmina

Veduta superiore

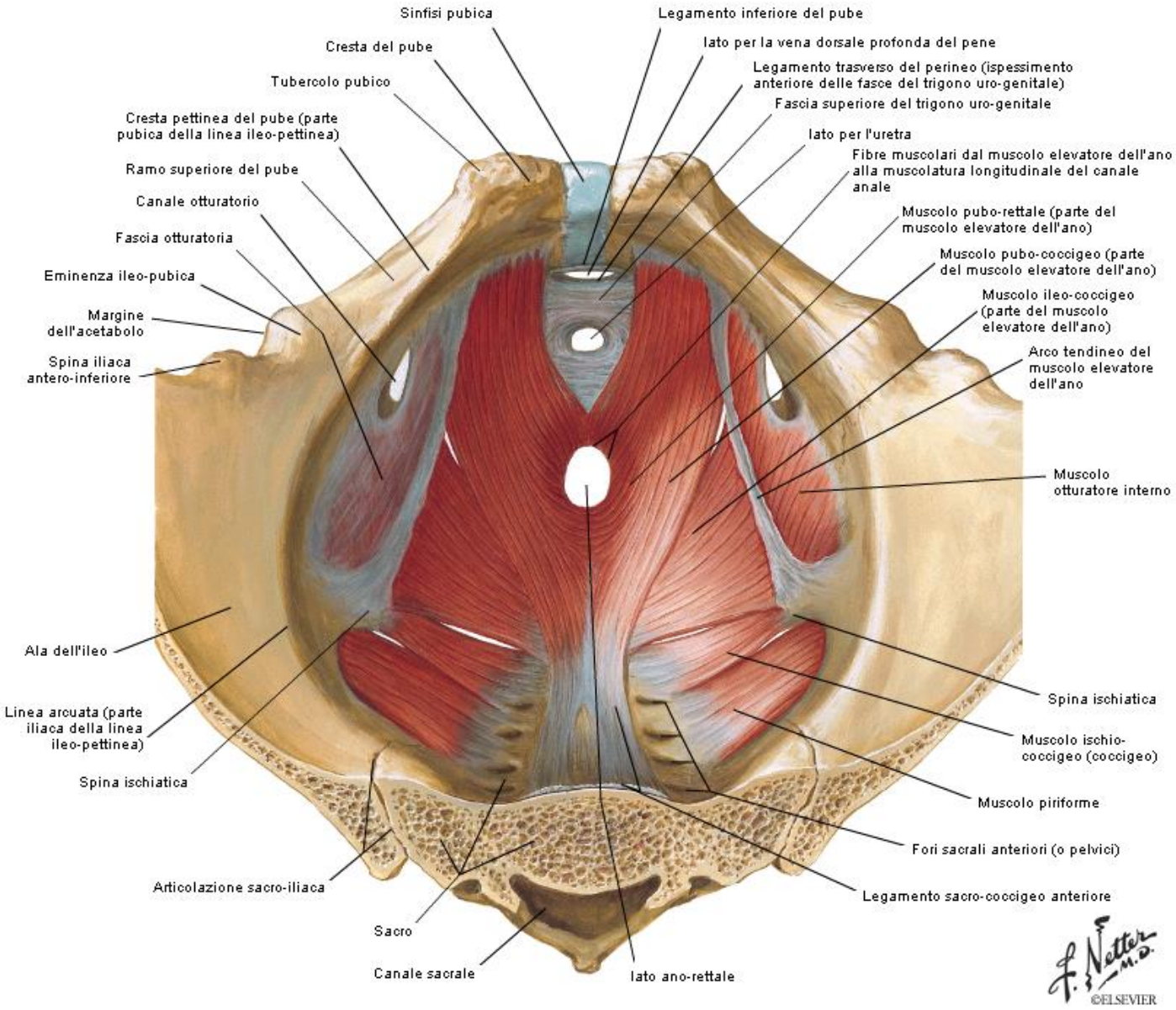


Utero, vagina e strutture di supporto



Diaframma pelvico nel maschio

Veduta superiore (visceri rimossi)



Possibili complicanze associate

. Reflusso vescico-ureterale
. Compromissione della funzionalità renale
. Calcolosi vescicale
. Acidosi metabolica

Standard
DR 1
15
15.01.19
12.52
/2
167cGy cm²

Standard
DR 1
11
15.01.19
12.46
/2
167cGy cm²

Quantificazione del problema

. A fronte di una percentuale di maschi sottoposti a ONB tra l’80 ed il 90%, l’incontinenza urinaria e l’ipercontinenza colpiscono prevalentemente le donne:

. Incontinenza diurna 10-43%

. Incontinenza notturna >50%

. Ipercontinenza 10-53%

Negli USA solo il 20% dei pazienti viene sottoposto ad ONB

COSA FARE?

. Selezione del paziente (età, comorbidità, stadio della neoplasia, compliance, incontinenza urinaria già presente, stenosi uretrali, counseling psicologico; accettazione ev. autocateterismo)

. Tecnica chirurgica: preservazione quando possibile dell’utero; preservazione dell’innervazione uretrale e perineale; « ricostruzione» dei mezzi di sospensione e supporto della vescica (sacrocolpopessia); serbatoio a basse pressioni

. Riabilitazione precoce

. Follow up anche funzionale (videourodinamica)

Decision Regret Related to Urinary Diversion Choice among Patients with Cystectomy

Devon K. Check,* Michael C. Leo, Matthew P. Banegas,† Joanna E. Bulkley, Kim N. Danforth, Scott M. Gilbert, Marilyn L. Kwan, Maureen O'Keeffe Rosetti and Carmit K. McMullen

Purpose: Patients who undergo cystectomy due to bladder cancer can elect an ileal conduit or a neobladder for urinary diversion. Decision regret related to this choice is an important and undesirable patient reported outcome. Our objective was to compare the severity of decision regret experienced by patients with a neobladder vs an ileal conduit.

Materials and Methods: We analyzed data from a longitudinal cohort study of patients who underwent cystectomy from 2013 to 2015. We applied multivariable linear regression to examine associations of the urinary diversion method (neobladder vs ileal conduit) with decision regret measured with the DRS (Decision Regret Scale) 6 and 18 months after cystectomy. Covariates included demographic and clinical characteristics, health care utilization and complications after cystectomy, quality of life and factors related to the decision making process, including informed and shared decision making, and goal concordance.

Results: Of the 192 patients in our cohort 141 received an ileal conduit and 51 received a neobladder. We observed no significant difference in the DRS score in patients with a neobladder vs an ileal conduit at 6 or 18 months (b=−1.28, 95% CI −9.07-6.53, vs b=−1.55, 95% CI −12.48-9.38). However, informed decision making was negatively related to decision regret at 6 and 18 months (b=−13.08, 95% CI −17.05-−9.11, and b=−8.54, 95% CI −4.26-−2.63, respectively). Quality of life was negatively associated with decision regret at 18 months (b=−5.50, 95% CI −8.95-−2.03).

Conclusions: Patients treated with cystectomy who were more informed about bladder reconstruction options experienced less regret independent of the method selected. Efforts to inform and prepare patients for the bladder reconstruction decision may help prevent decision regret.

Key Words: urinary bladder neoplasms, decision making, cystectomy, urinary diversion, choice behavior

Abbreviations and Acronyms

BCI = Bladder Cancer Index
BCOOL = Bladder Cancer QOL
COH-QOL = City of Hope QOL
DRS = Decision Regret Scale
ED = emergency department
OLS = ordinary least squares
QOL = quality of life

Accepted for publication August 12, 2019.

Editor's Note: This article is the ••• of 6 published in this issue for which category 1 CME credits can be earned. Instructions for obtaining credits are given with the questions on pages ••• and •••

In 2018 more than 60,000 men and 18,000 women were diagnosed with bladder cancer in the United States.[1] In the 30% of patients diagnosed with invasive cancer and in select patients with high risk noninvasive disease radical cystectomy (surgical removal of the bladder) is a standard treatment recommendation.[2] Most patients who undergo radical cystectomy can choose between 2 methods, namely bladder reconstruction or urinary diversion.[3]

The most common method, accounting for approximately 80% of diversions

THE JOURNAL OF UROLOGY®
https://doi.org/10.1097/JU.0000000000000512
Vol. 203, 1-5, January 2020
Printed in U.S.A.

available at www.sciencedirect.com
journal homepage: www.europeanurology.com/eufocus

Urothelial Cancer

Midterm Health-related Quality of Life After Radical Cystectomy: A Propensity Score–matched Analysis

Alexander Kretschmer *, Tobias Grimm, Alexander Buchner, Friedrich Jokisch, Brigitte Ziegelmüller, Jozefina Casuscelli, Gerald Schulz, Christian G. Stief, Alexander Karl

Department of Urology, Ludwig-Maximilians-University, Munich, Germany

Article info

Article history:
Accepted February 25, 2019

Associate Editor: Derya Tilki

Keywords:
European Organization for Research and Treatment of Cancer QLQ-C30
Radical cystectomy
Urinary diversion
Health-related quality of life

Abstract

Background: Radical cystectomy (RC) and urinary diversion affect various dimensions of patients' health-related quality of life (HRQOL). Knowledge regarding patient-reported HRQOL following RC is mainly based on retrospective findings of cross-sectional studies.
Objective: To provide data from a large prospective propensity score–matched cohort with a systematic follow-up of up to 2 yr.
Design, setting, and participants: A total of 134 consecutive patients who underwent RC and ileal conduit (IC) or orthotopic ileal neobladder (ONB) urinary diversion in a tertiary care centre were prospectively enrolled, and a propensity score matching analysis based on American Society of Anesthesiologists score, age, and tumour stage was performed. Exclusion criteria encompassed age <30 yr and RC due to benign diseases. HRQOL was addressed with the validated European Organization for Research and Treatment of Cancer QLQ-C30 questionnaire. HRQOL was assessed preoperatively, and at 3, 12, and 24 mo postoperatively. Of the nondeceased patients, 85.1% (IC) and 78.2% (ONB) completed the study.
Intervention: RC.
Outcome measurements and statistical analysis: The primary endpoint was good general HRQOL based on previously published cut-off values. Secondary endpoints encompassed the respective HRQOL domains. Univariate and multivariate analyses were performed using binary logistic regression models.
Results and limitations: In the longitudinal analysis of RC patients, functioning and symptoms scores show a similar natural HRQOL course for IC and ONB patients. After 24 mo, general HRQOL was significantly higher in the ONB subcohort (60.5 vs 73.5, p = 0.013). Good general HRQOL was reached by 32.4 (IC) versus 61.1% (ONB; p = 0.019). In the multivariable analysis, ONB was not an independent predictor of good HRQOL (odds ratio 2.211, 95% confidence interval 0.684–7.150, p = 0.185). Limitations include the nonbladder specificity of the QLQ-C30 questionnaire and the small sample size.
Conclusions: The current study provides prospective data from a unique propensity score–matched contemporary patient cohort. We display the natural history of general HRQOL and its subdomains without observing significantly higher midterm postoperative HRQOL in patients undergoing continent urinary diversion in the multivariable analysis.
Patient summary: We analyse the health-related quality of life (HRQOL) of European patients who underwent radical cystectomy due to bladder cancer and found that HRQOL was slightly better for orthotopic ileal neobladder than for ileal conduit urinary diversion after 24 mo.

© 2019 European Association of Urology. Published by Elsevier B.V. All rights reserved.

* Corresponding author. Department of Urology, Ludwig-Maximilians-University, Marchioninistrasse 15, Munich 81377, Germany. Tel.: +4989 4400 0; Fax: +49894400 75444.
E-mail address: alexander.kretschmer@med.uni-muenchen.de (A. Kretschmer).

https://doi.org/10.1016/j.euf.2019.02.017
2405-4569/© 2019 European Association of Urology. Published by Elsevier B.V. All rights reserved.

Please cite this article in press as: Kretschmer A, et al. Midterm Health-related Quality of Life After Radical Cystectomy: A Propensity Score–matched Analysis. Eur Urol Focus (2019), https://doi.org/10.1016/j.euf.2019.02.017

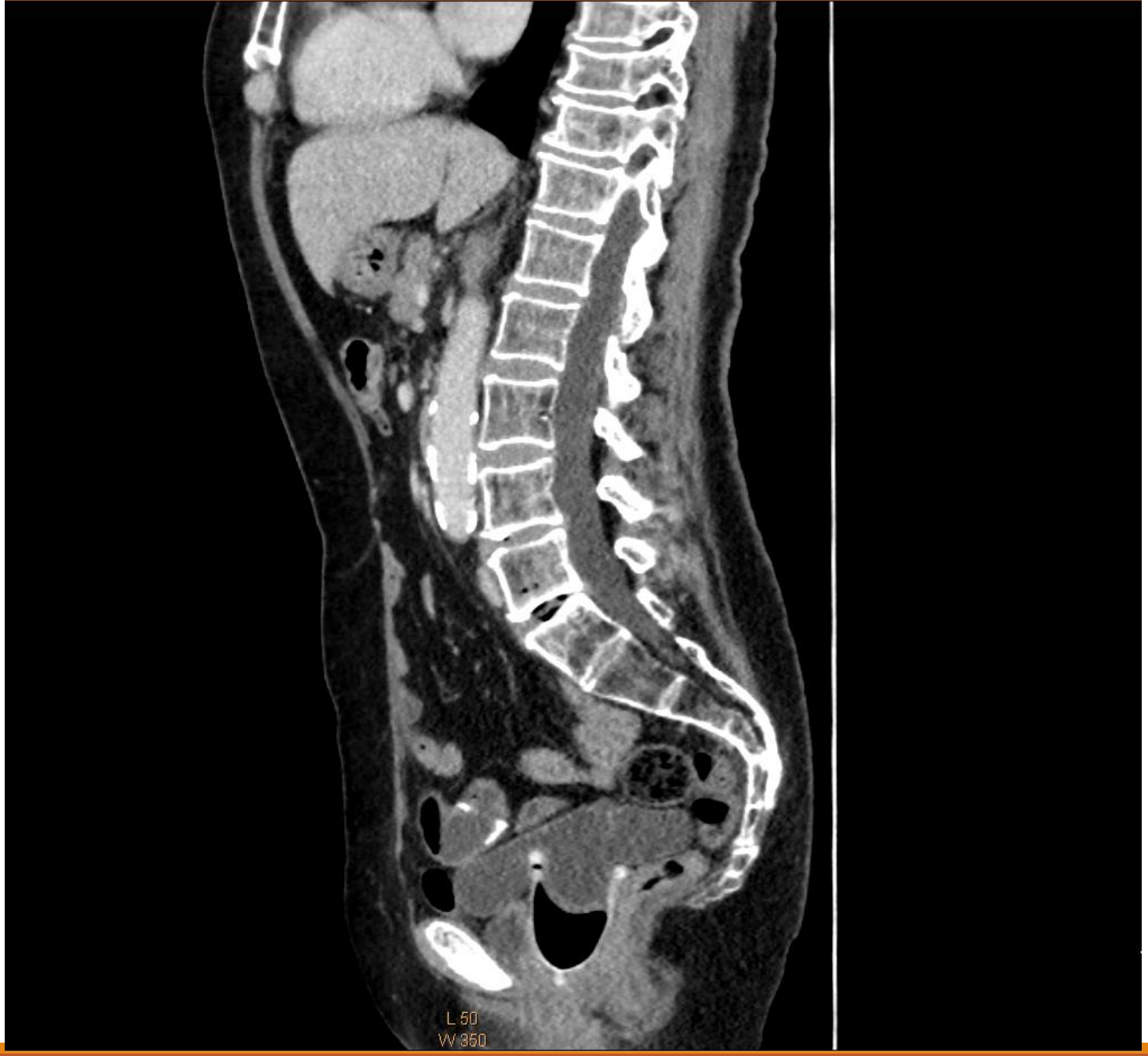
Terapia dell’incontinenza

. Conservativa: utilizzo di mezzi che comprimono l’uretra

. Chirurgica

- . Iniezione di sostanze volumizzanti (bulking agents), peraltro poco efficaci
- . TOT o TVT (pochi casi descritti, viste le complicanze)
- . Nei maschi, possibile impianto di sling regolabili
- . Protesi sfinteriche, sempre nei maschi

4 fori che facilitano
l'aderenza alle pareti
della vagina
Linee che aiutano
ad afferrare
nell'inserimento
ed estrazione
Gambo piatto con
linee che facilita
l'estrazione
NaturalMamma


L 50
W 350

Basta che funzioni
scritto e diretto da WOODY ALLEN

Terapia della ritenzione

Unico presidio efficace è il cateterismo intermittente pulito, che peraltro è dimostrato riduce l’entità dell’incontinenza

Cosa faremo?

PubMed

Format: Abstract

Full text links

WILEY Full Text Article

Neurourol Urodyn. 2019 Nov;38(8):2070-2076. doi: 10.1002/nau.24147. Epub 2019 Aug 20.

Detrusor underactivity in women: A current understanding.

Hartigan SM[1], Reynolds WS[1], Dmochowski RR[1].

Author information

1 Department of Urology, Vanderbilt University Medical Center, Nashville, Tennessee.

Abstract

AIMS: To examine the current understanding and management of detrusor underactivity (DUA) and underactive bladder (UAB) in women.

METHODS: A review of the current literature was performed with a specific focus on new management strategies and treatment options for women with DUA and UAB.

RESULTS: DUA has become an area of increased interest in recent years. Affecting up to 45% of older women undergoing urodynamic evaluation for non-neurogenic lower urinary tract symptoms, DUA is common. There are a variety of possible etiologies including neurogenic or myogenic dysfunction. As there is currently no cure for DUA and no way to restore the ability of the detrusor muscle to contract, management of DUA in women is mostly focused on effective bladder drainage by urinary catheterization. Clean intermittent catheterization is the gold standard for bladder drainage however for a variety of reasons, women with DUA often are managed with indwelling urethral catheter or suprapubic tube. Medications, sacral neuromodulation, and the inFlow urinary prosthesis are also treatment alternatives or additions to catheterization. Novel therapies using stem cells and gene therapy are also under investigation for the treatment of DUA and UAB.

CONCLUSIONS: DUA is likely more prevalent than recognized and undertreated in women. It is vital that further research in treatment options beyond catheterization be developed for these patients to offer patients a variety of treatment options.

© 2019 Wiley Periodicals, Inc.

KEYWORDS: detrusor underactivity; female voiding dysfunction; urinary retention

PMID: 31432566 DOI: 10.1002/nau.24147

Publication type

LinkOut - more resources