SUPRAPUBIC TUBE (SPT) PLACEMENT DURING ROBOT-ASSISTED LAPAROSCOPIC PROSTATECTOMY

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ABSTRACT

Robot-assisted laparoscopic prostatectomy (RALP) is a widely accepted surgery for the treatment of localized prostate cancer. The benefits of this procedure compared to open prostatectomy have been described in the literature include: decreased blood loss, shorter convalescence, earlier return of continence and improved cosmesis1-3. Overall, recovery is generally uneventful and smooth however patients do complain about discomfort secondary to their urethral catheter (UC).

UC is traditionally used during the postoperative course after robot-assisted laparoscopic prostatectomy (RALP) for bladder drainage presumably to bridge the anastomotic line through cross-healing thus preventing a urethrovesical anastomotic stricture. However catheter associated discomfort, specifically meatal irritation and penile pain are common postoperative complaints expressed by the patient.4,5 The use of a percutaneous suprapubic tube (SPT) has been proposed as an alternative to a UC for postoperative drainage after RALP.6,7 Accordingly our experiences, the SPT is well tolerated by patients and associated with minimal penile pain compared to the UC.

In this article, surgical technique of suprapubic tube placement (SPT) during RARP is explained.

Key Words: Suprapubic tube (SPT) placement, Robotic surgery, Prostate cancer, Quality of life

SUPRAPUBIC TUBE (SPT) PLACEMENT TECHNIQUE

Following a one-layer running urethrovessical anastomosis with a 3-0 barbed –continued suture (V-Loc™), bladder is filled with 300 mL of saline via the UC to inspect for possible urine leak and to distend the bladder for identification of the optimal insertion site for the SPT (Figure 1).

The midline SPT placement site is identified by measuring a 2 centimeter distance cephalad to the pubic symphysis. Application of pressure by the bedside assistant over the potential placement site aids in the alignment of the anterior abdominal wall incision-site with the optimal bladder insertion-site. A one centimeter incision is made in the skin overlying the insertion sight and a spiked introducer (Lawrence Supra-Foley Introducer®, Utah Medical Products Inc., Midvale, UT, USA) is placed through the anterior abdominal wall under direct vision and then advances into the bladder with the assistance of the console surgeon pushing up on the distended bladder (Figure 2).

The trocar is removed and through the sheath a 16 French catheter is inserted into the bladder and the balloon inflated with 10 milliliters of sterile water (Figure 3).

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The catheter is then secured to the skin using a 3-0 nylon suture and a 3-0 barbed suture (V-Loc™) is placed in purse-string fashion around the SPT securing the bladder to the anterior abdominal wall (Figure 4A,B).

REFERENCES


Figure 1: The bladder is filled with 300 mL of saline and vigorously compressed without any extravasation from the anastomosis.

Figure 2: With the bladder still full; however, through a separate midline stab incision, an access sheath is advanced to the bladder.

Figure 3: An access sheath is advanced into the bladder through which a 16-French Foley catheter is placed and a suprapubic tube.

Figure 4 (A,B): The bladder itself is secured to the anterior abdominal wall with a pursestring suture.


