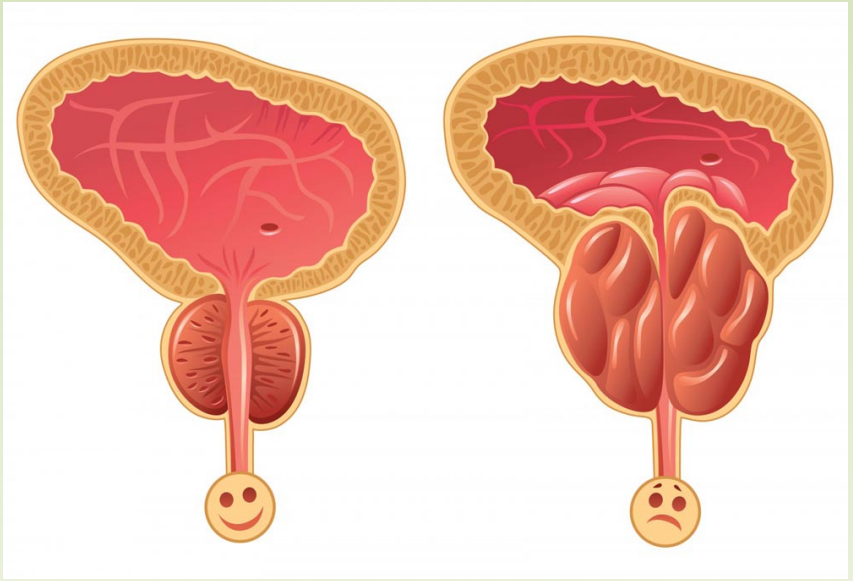
PAZIENTE UROLOGICO: RIABILITAZIONE E CURE TRASVERSALI

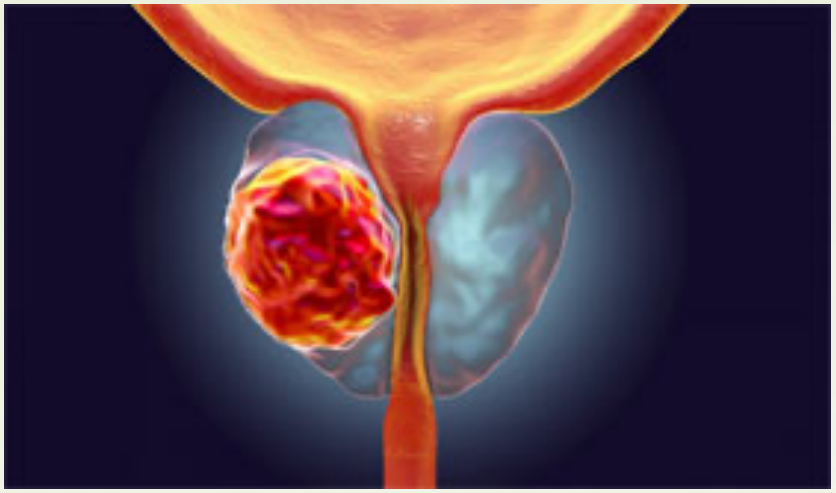
LA MALATTIA PROSTATICA : Quali necessità terapeutiche e riabilitative

Dott.ssa Luisa Zegna

IPERTROFIA PROSTATICA BENIGNA



CARCINOMA PROSTATICO



IPERTROFIA PROSTATICA BENIGNA: terapia medica

T. MEDICA

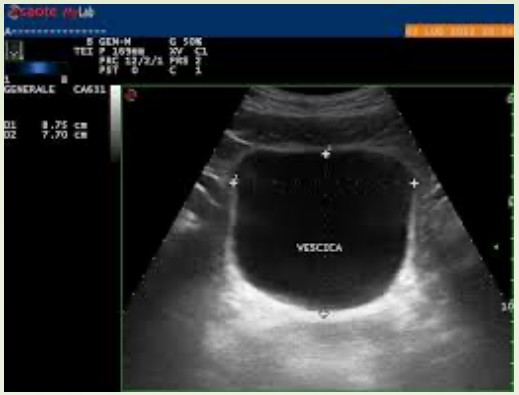
- ALFA-LITICI — ALFUZOSINA,TAMSULOSINA , TERAZOSINA DOXAZOSINA, PRAZOSINA, SILODOSINA
- INIBITORI 5-α-Reduttasi — FINASTERIDE, DUTASTERIDE
- FITOTERAPICI — SERENOA REPENS, PIGEUM AFRICANUM, URTICA DIOICA
- ANTIMUSCARINICI & β-AGONISTI — TOLTERODINA, MIRABEGRON
- INIBITORI PDE-5 — TADALAFIL

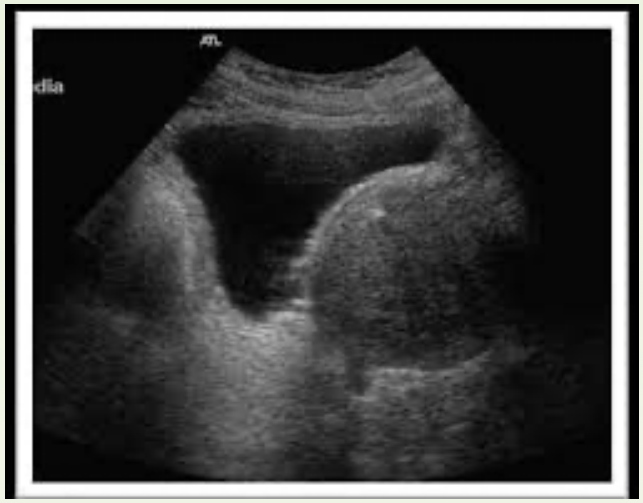
PZ NON CANDIDABILE PER ETA'/COMORBILITA'AD INTERVENTO CHIRURGICO

PZ CHE RIFIUTA INTERVENTO CHIRURGICO

T. CONSERVATIVA

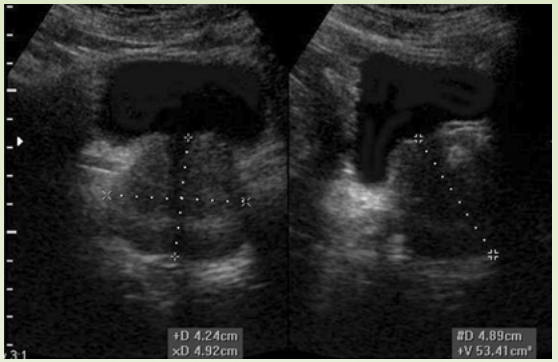
RITENZIONE URINARIA ACUTA/CRONICA

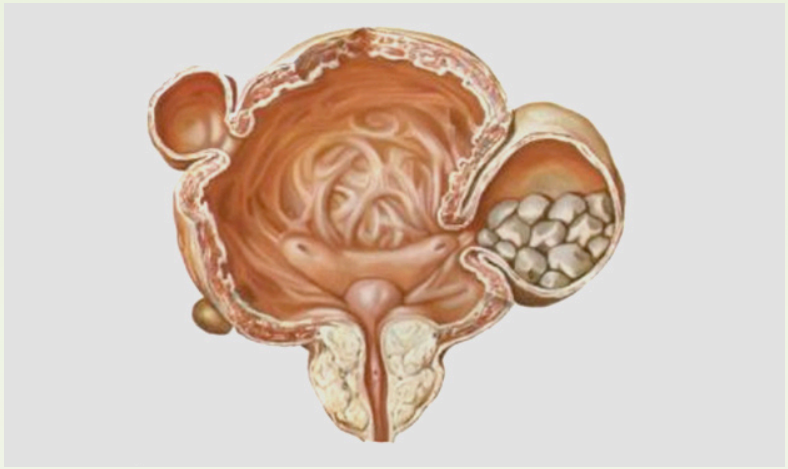


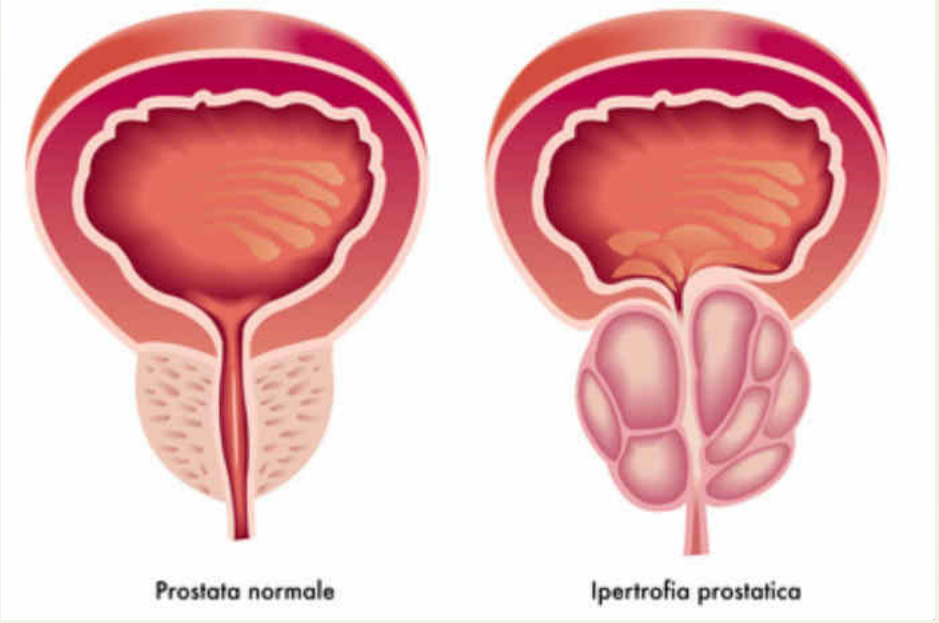


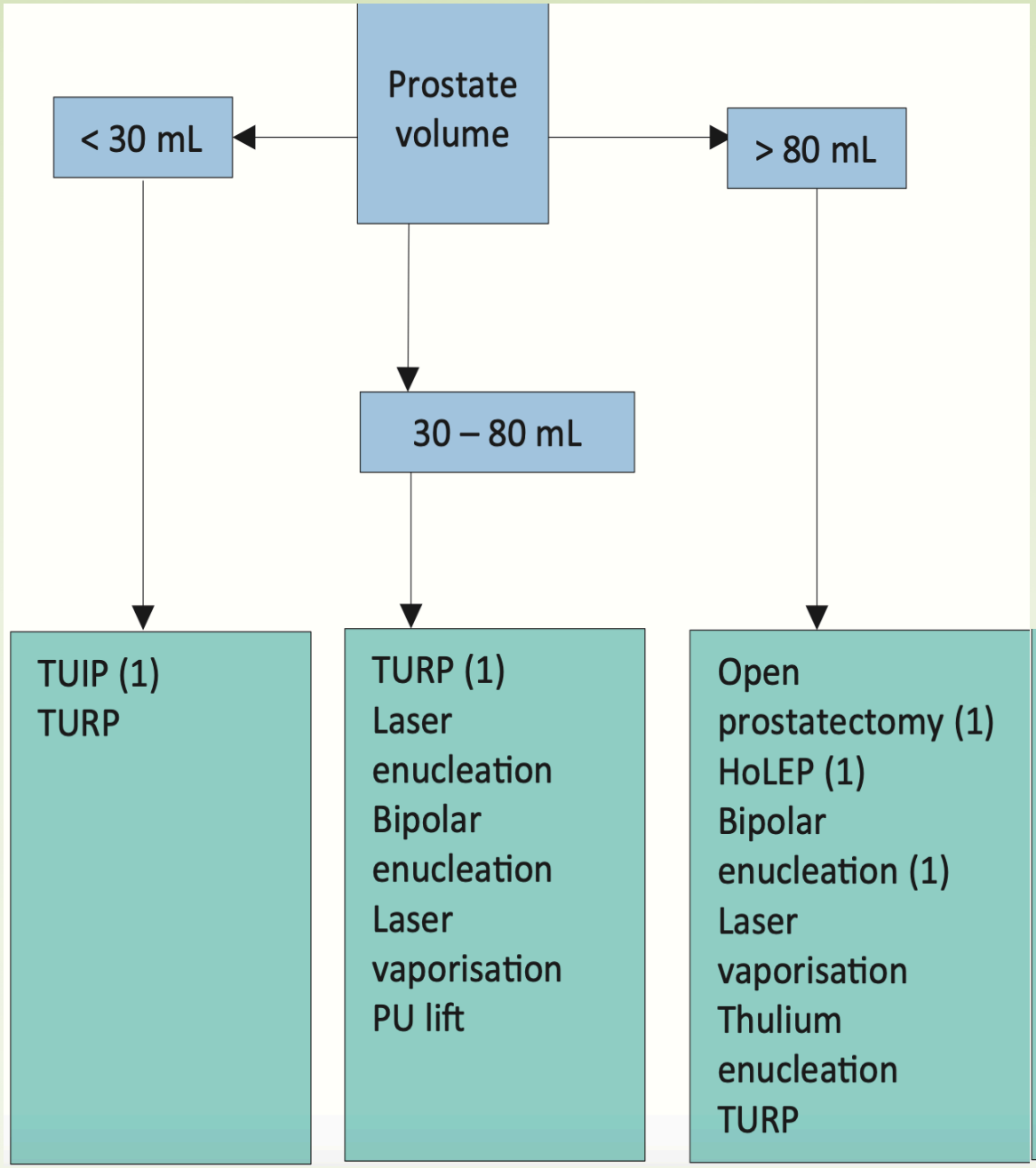
IPERTROFIA PROSTATICA BENIGNA: terapia chirurgica

- Non responder a terapia medica
- Riduzione importante dei valori di Qmax
- Mancata gestione dei sintomi
- Ematuria prostatica
- Segni di scompenso vescicale
- Residuo post-minzionale elevato
- Diverticoli vescicali
- Calcolosi vescicale
- IVU ricorrenti
- Ritenzione urinaria acuta

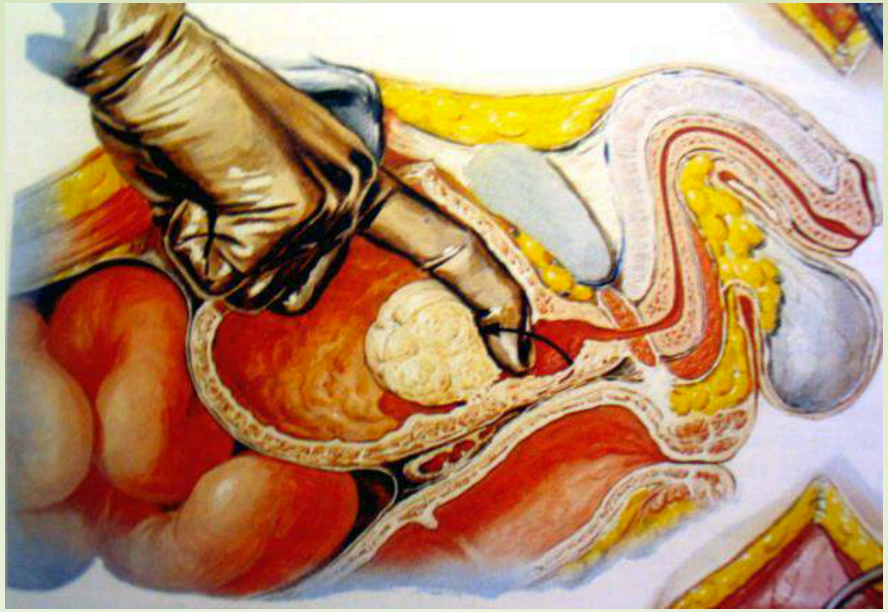




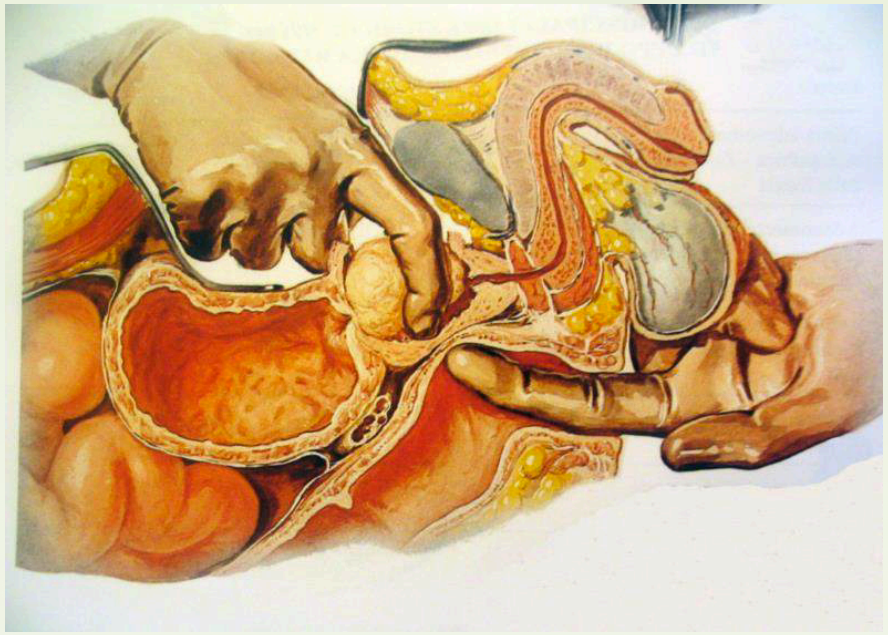


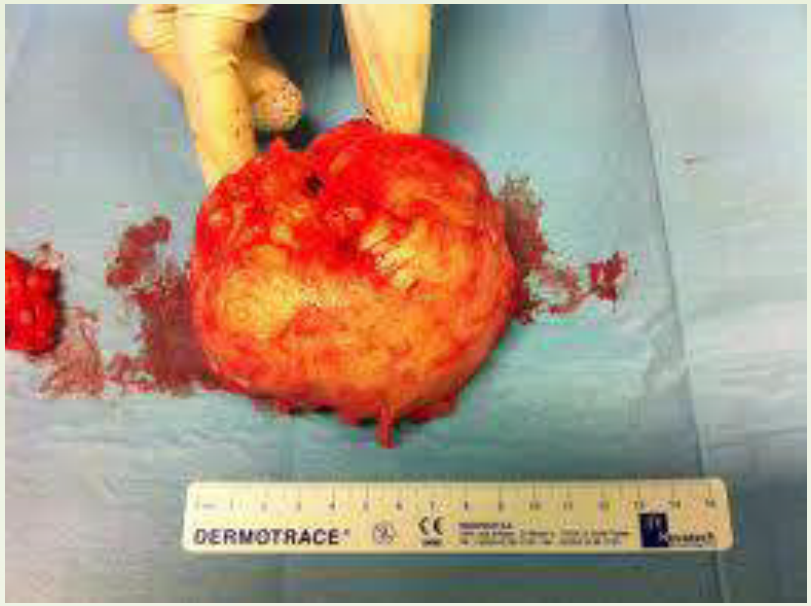


- **Resection**
- **Enucleation**
- **Vaporisation**
- **Alternative ablative techniques**
- **Non-ablative techniques**

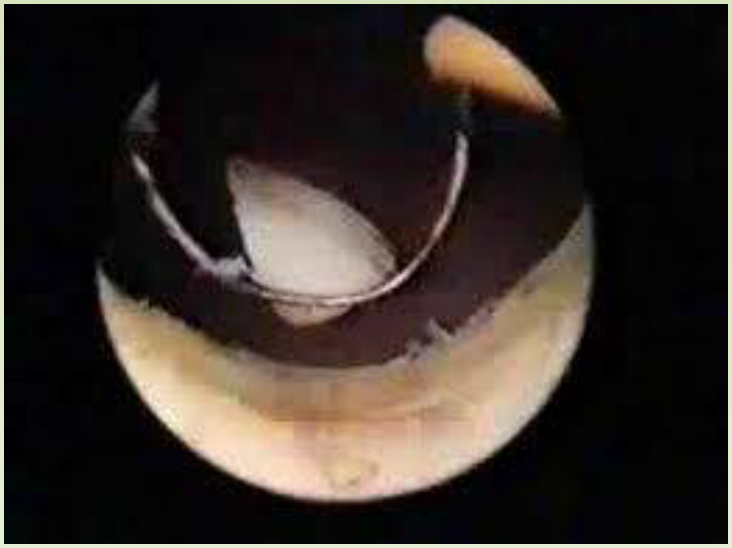


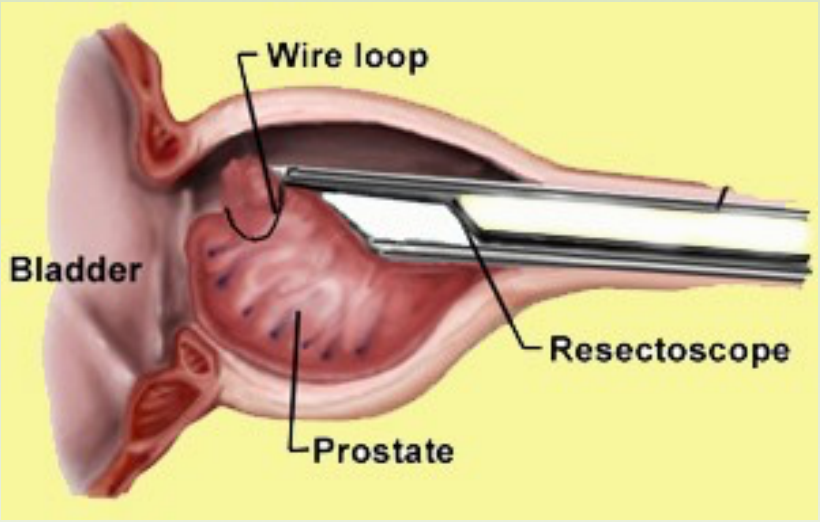
ADENOMECTOMIA

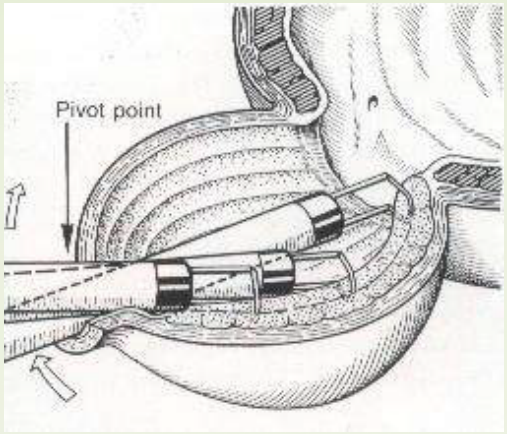


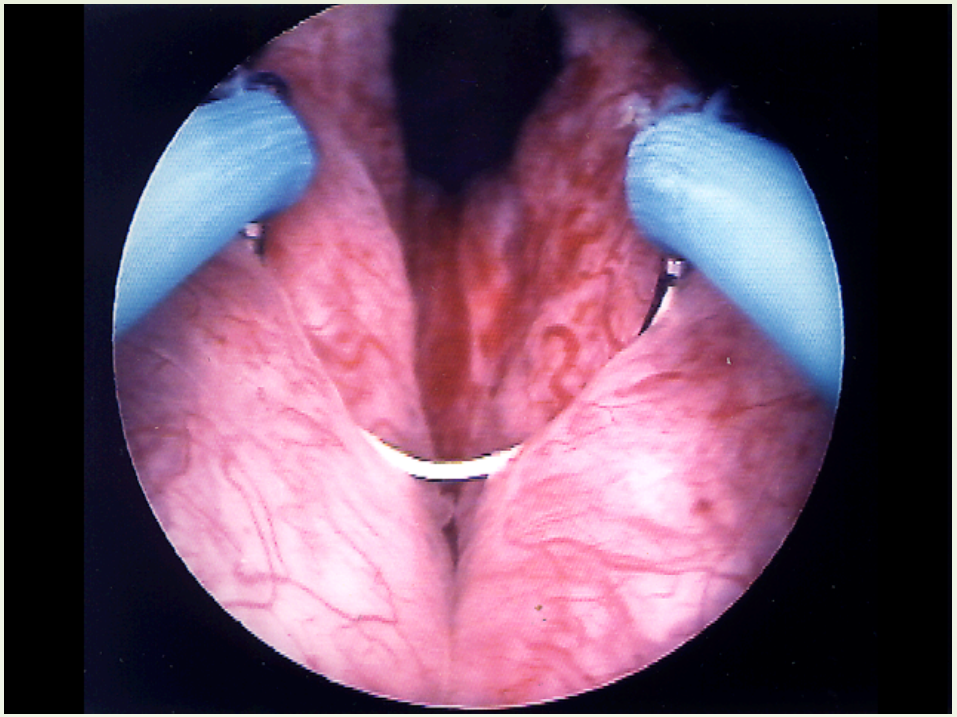


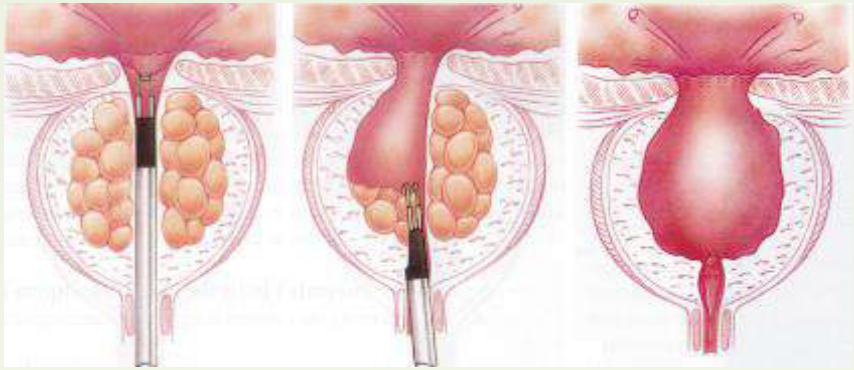
TURP





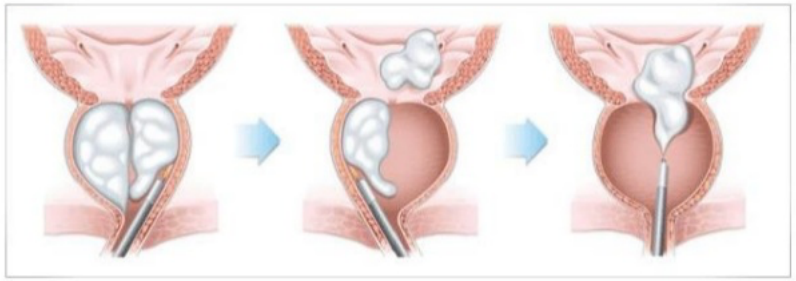




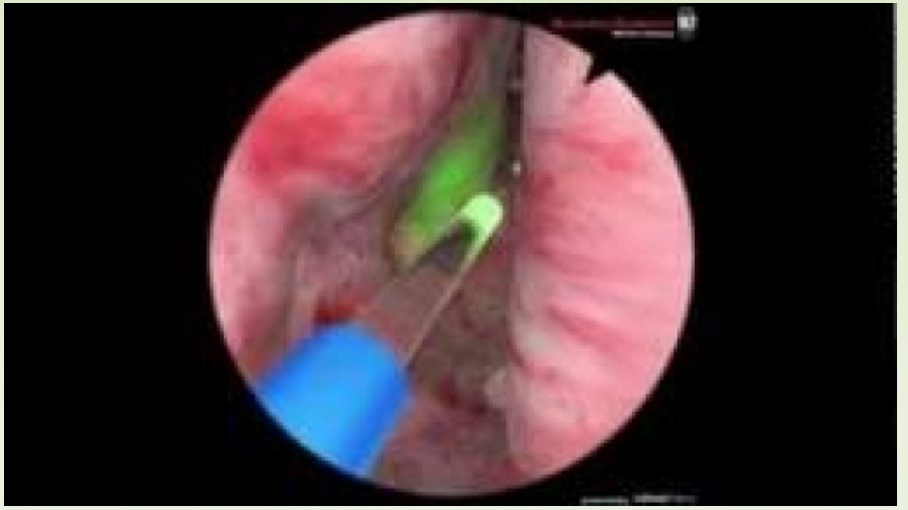


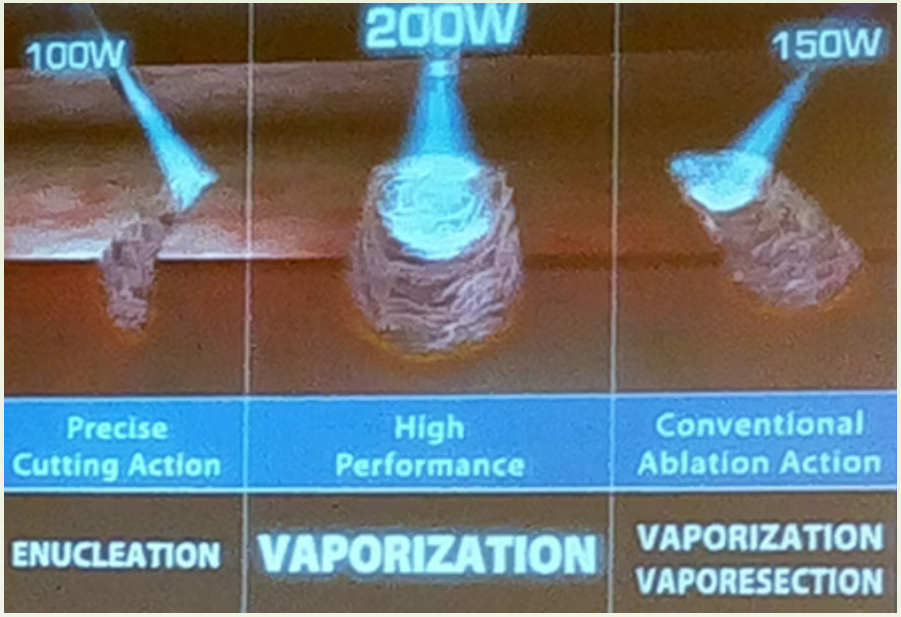
LASER

Holmium Laser Enucleation of the Prostate (HoLEP)



Prostate lobes enucleated from capsule into bladder

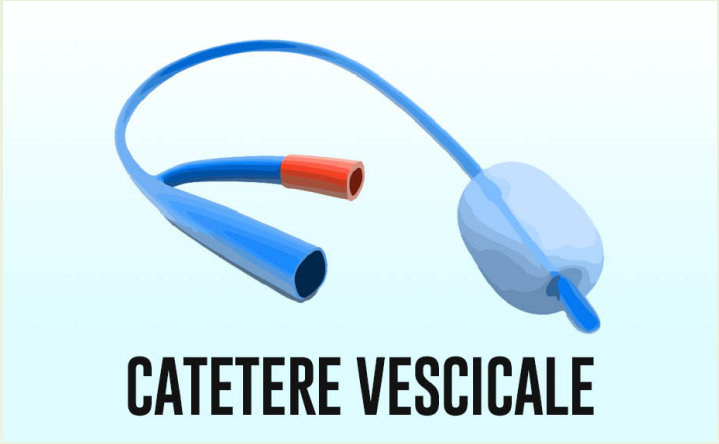




COMPLICANZE/CONSEGUENZE DELLA DISOSTRUZIONE:

Eiaculazione retrograda per resezione del collo vescicale (sfintere liscio)
Sanguinamento intra e postoperatorio
Incontinenza urinaria
TUR sindrome
IVU
Stenosi uretrali

IPO/ACONTRATTILITA' DETRUSORIALE: elevati ristagni



EAU Guidelines on Neuro-Urology

NEURO-UROLOGY - LIMITED UPDATE APRIL 2024

Recommendations	Strength rating
Use intermittent catheterisation as a standard treatment for patients who are unable to empty their bladder.	Strong
Thoroughly instruct patients in the technique and risks of intermittent catheterisation.	Strong
Avoid indwelling transurethral and suprapubic catheterisation whenever possible.	Strong

Indwelling catheter vs intermittent catheterization: is there a difference in UTI susceptibility?

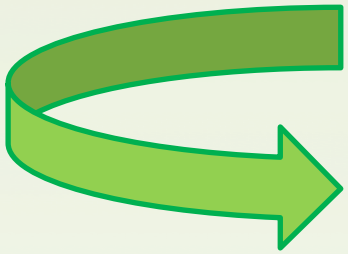
Vera Neumeier[1†], Fabian P. Stangl[2†], Joëlle Borer[1,3], Collene E. Anderson[1,4,5], Veronika Birkhäuser[1], Oksana Chernych[1], Oliver Gross[1], Miriam Koschorke[1], Jonas Marschall[6], Shawna McCallin[1], Ulrich Mehnert[1], Helen Sadri[1], Lara Stächele[1], Thomas M. Kessler[1] and Lorenz Leitner[1*]

In our patient population with NLUTD, we did not find relevant differences in UTI frequency for patients using an indwelling catheter compared to those performing IC, however, characteristics of microbiological findings were different between groups. While IC is the preferred management for patients with NLUTD who cannot effectively empty their bladders, as it is associated with fewer general complications, infectious outcomes seem to be similar with patients using an indwelling catheter. The microbiological characteristic further indicate that urine cultures are mandatory in case of UTIs prior antibiotic therapy in this population.

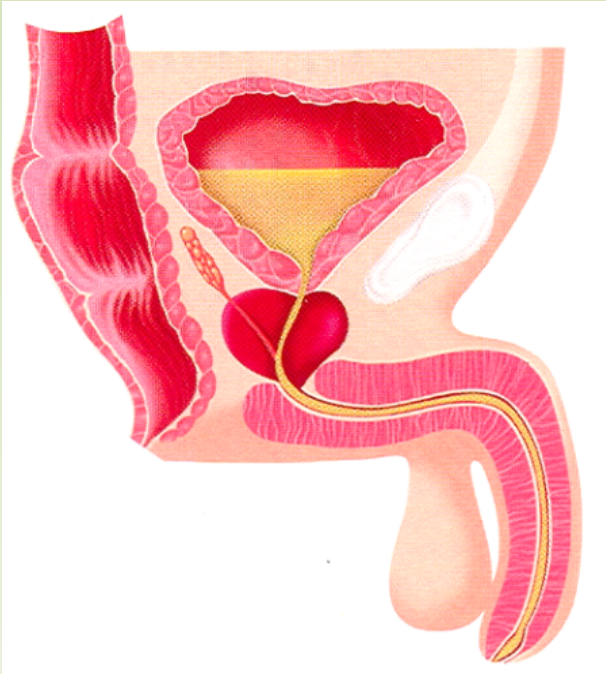
CARCINOMA PROSTATICO

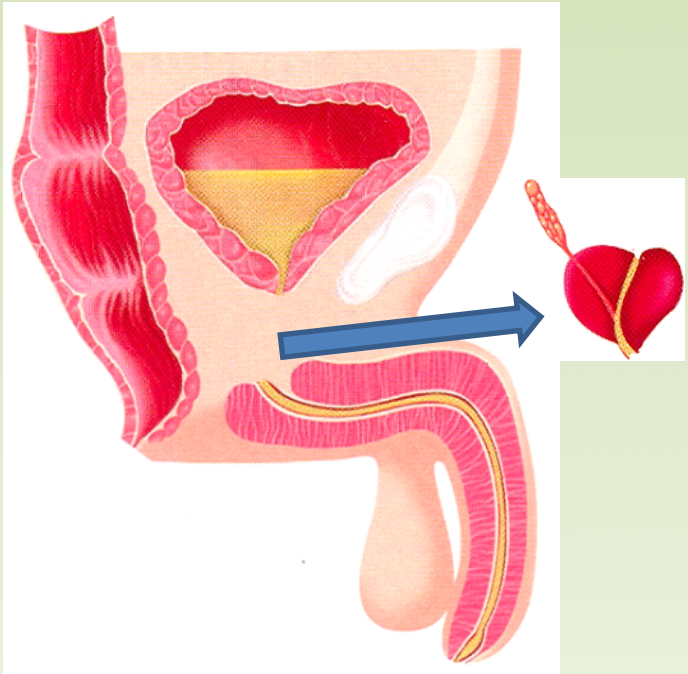
- Sorveglianza attiva
- Radioterapia (a fasci esterni, brachiterapia)
- HIFU
- Crioterapia
- Ormonoterapia, chemioterapia

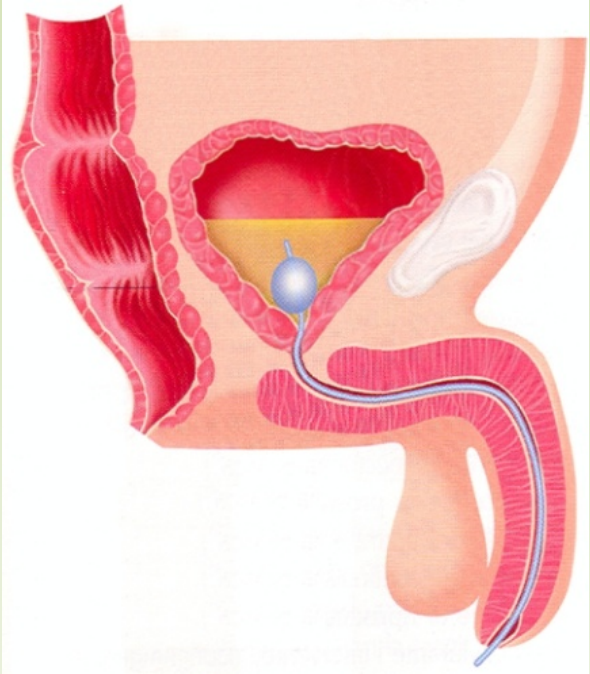
- **Prostatectomia radicale**

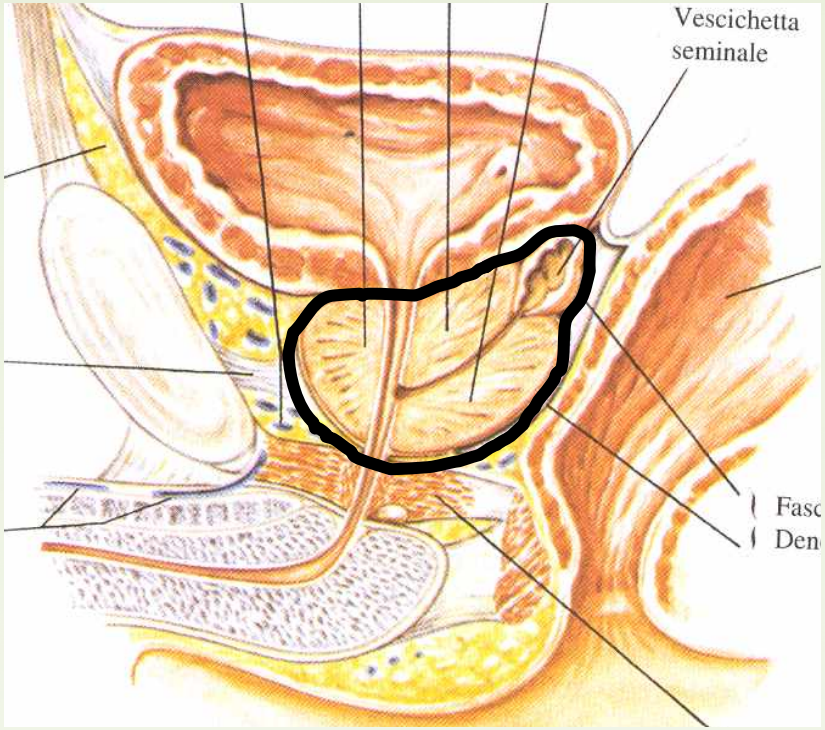


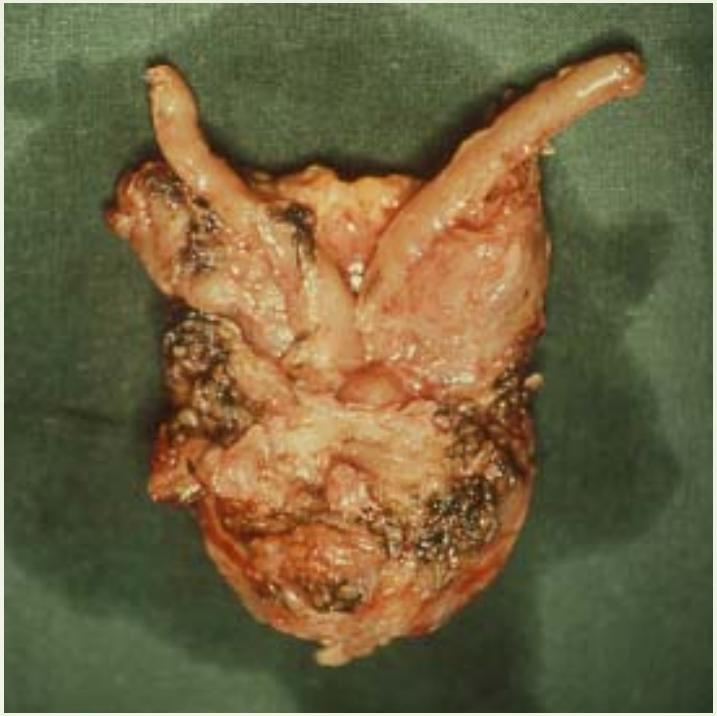
Aspettativa di vita > 10 anni
Assenza di significative comorbidità
Malattia a rischio basso-intermedio
Controversa l'indicazione negli alti rischi

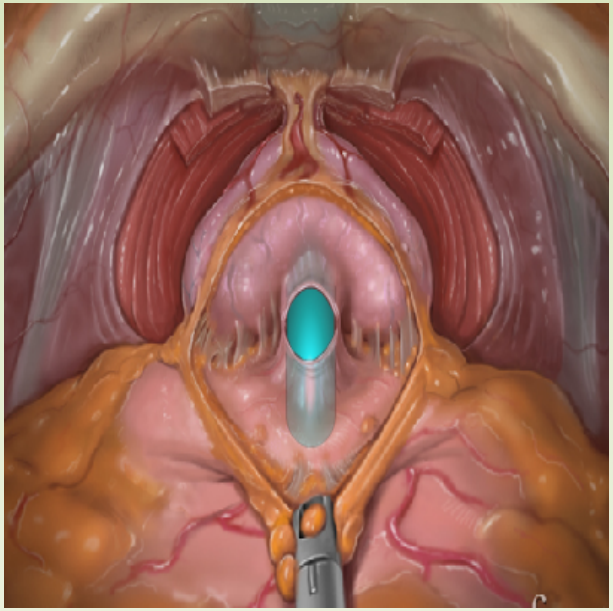


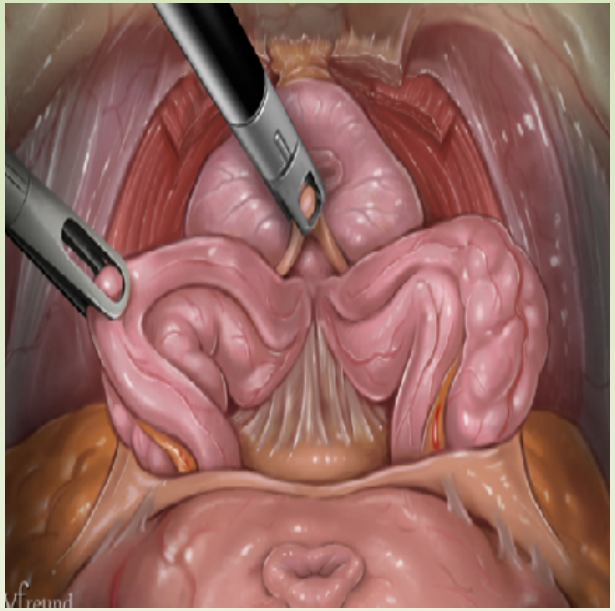


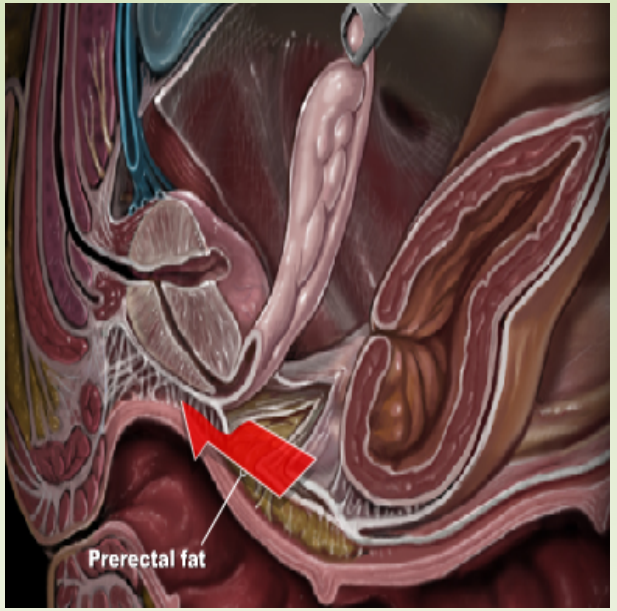


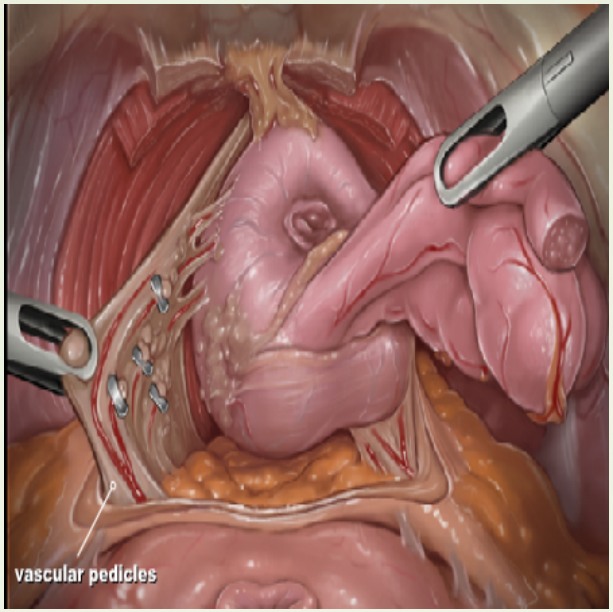

Vescichetta
seminale

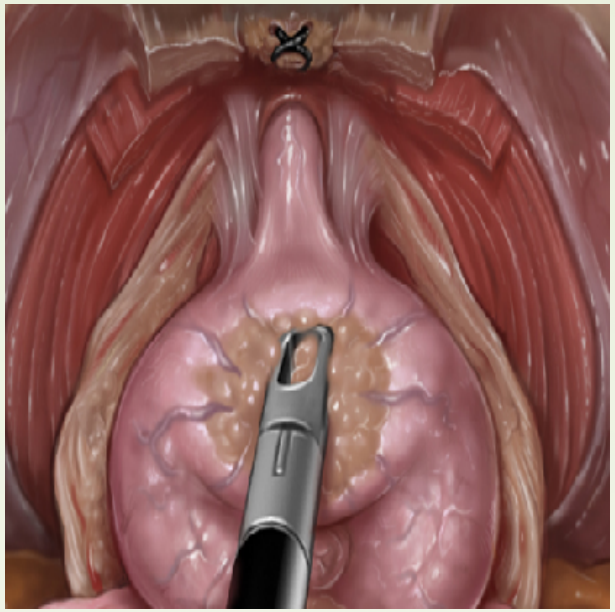


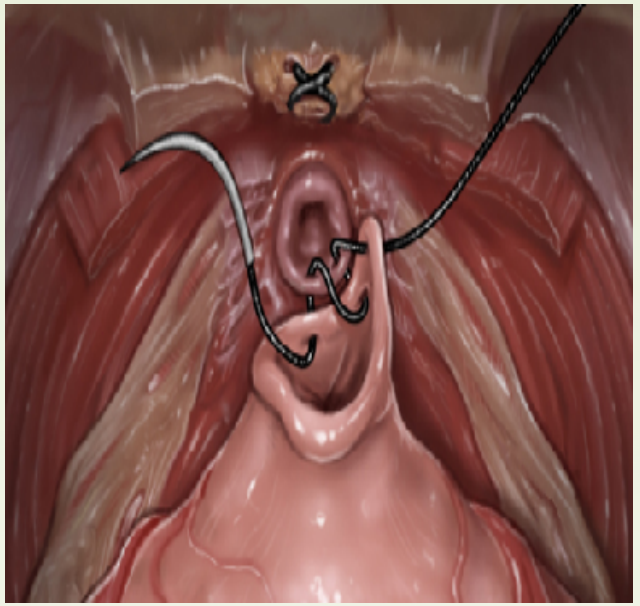





Prerectal fat


vascular pedicles





Guidelines on
Prostate Cancer

A. Heidenreich (chairman), P.J. Bastian, J. Bellmunt, M. Bolla, S. Joniau, M.D. Mason, V. Matveev, N. Mottet, T.H. van der Kwast, T. Wiegel, F. Zattoni

European Association of Urology

Complication	Incidence (%)
Perioperative death	0.0-2.1
Major bleeding	1.0-11.5
Rectal injury	0.0-5.4
Deep venous thrombosis	0.0-8.3
Pulmonary embolism	0.8-7.7
Lymphocoele	1.0-3.0
Urine leak, fistula	0.3-15.4
Slight stress incontinence	4.0-50.0
Severe stress incontinence	0.0-15.4
Impotence	29.0-100.0
Bladder neck obstruction	0.5-14.6
Ureteral obstruction	0.0-0.7
Urethral stricture	2.0-9.0

Incontinenza urinaria

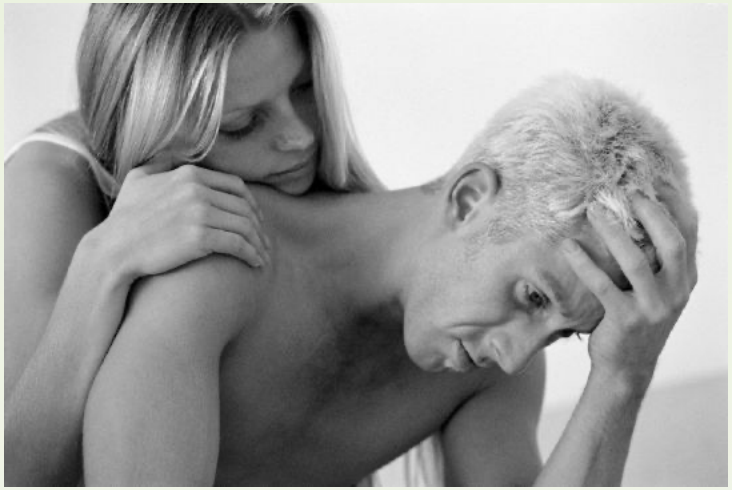
- **Definition 1: total control without any pad or leakage**
- **Definition 2: no pad use but loses a few drops of urine**
- **Definition 3: use no or one pad per day**

- **Deficit sfintere intrinseco**

- Disfunzione vescicale:
  → instabilità detrusoriale
  → riduzione compliance

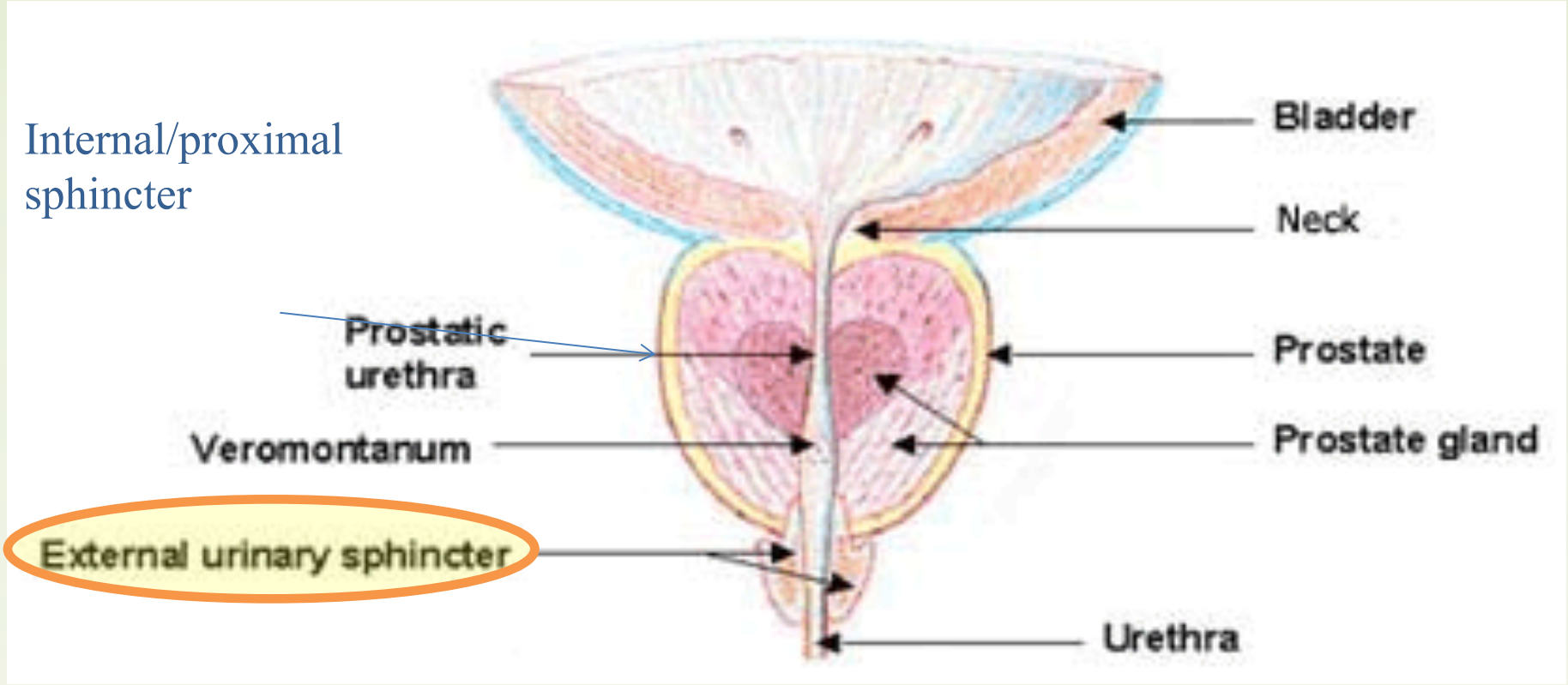
- **Lesione dei bundles neurovascolari**

- Fattori combinati



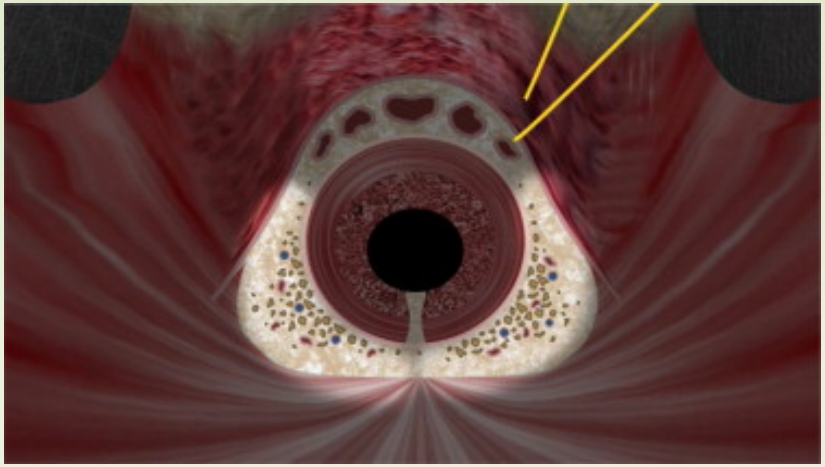
SFINTERE URINARIO **INTERNO liscio** avvolto a cappio **attorno all'uretra**. Ha la funzione di chiudere l'uretra per **trattenere l'urina** ed impedirne l'eiaculazione retrograda nella vescica. Spesso è danneggiato a causa di una prostatectomia radicale

SFINTERE URINARIO **ESTERNO striato** dell'uretra, situato **sotto la prostata**, è il muscolo **esterno responsabile della chiusura volontaria dell'uretra**



SFINTERE LISCIO **INTRAMURALE**

Costituito dall ‘insieme dei muscoli lisci in relazione intima con l’uretra, che vanno dal collo vescicale fino all ‘aponeurosi perineale media. E’ particolarmente sviluppato a livello dell ‘uretra membranosa



COMPONENTE **INTRAMURALE**

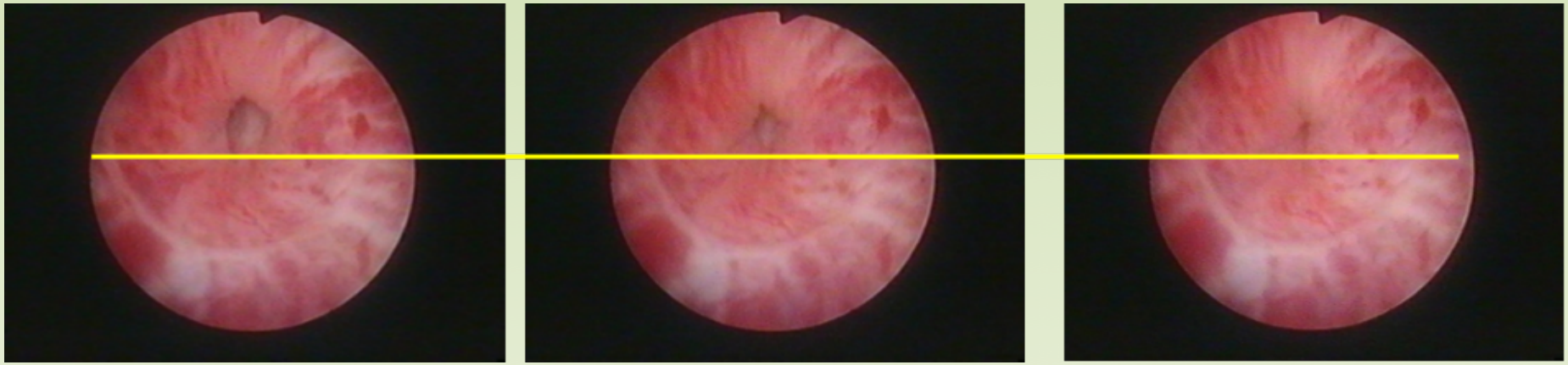
innervata dai nervi pelvici e responsabile della continenza passiva

SFINTERE STRIATO **PERIURETRALE**

Formato dai restanti muscoli provenienti dallo sfintere cloacale e dai fasci interni del pubo-coccigeo in stretta relazione con l’uretra, ma di origine embriologica diversa

COMPONENTE **PERIURETRALE**

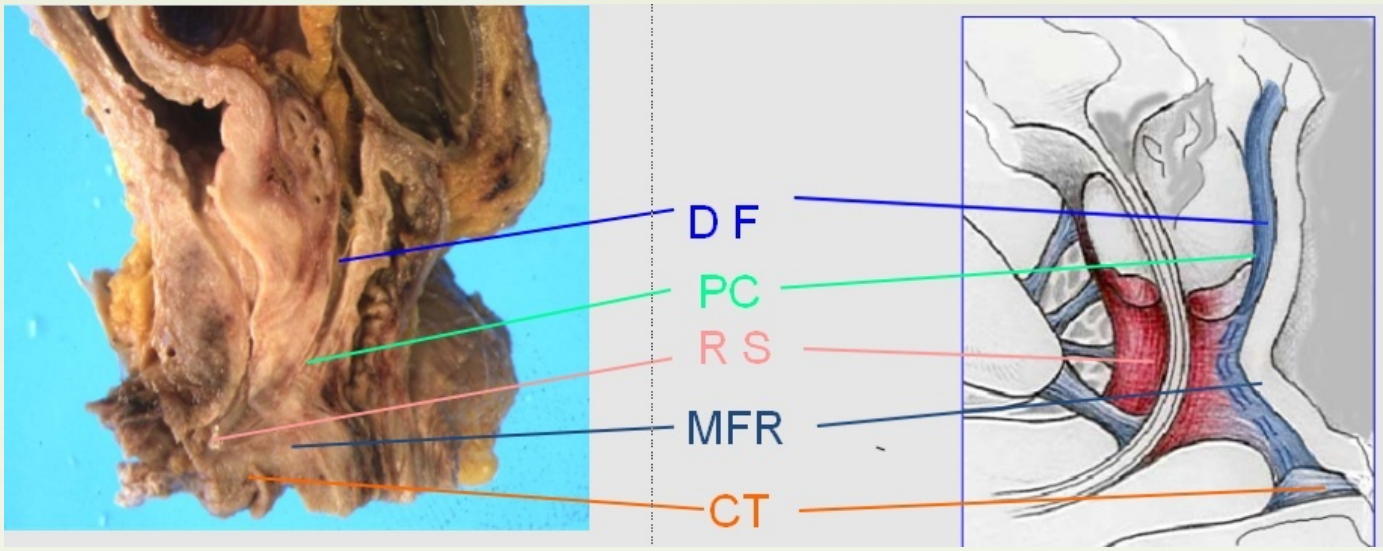
innervata dal nervo pudendo esercita il meccanismo di chiusura uretrale quando aumenta la pressione addominale



Le pareti anterolaterali hanno la forma di un ferro di cavallo e permettono la contrazione da anterolaterale a **posteriore della parete dello sfintere**

Il **rafe fibroso mediano** è il fulcro della contrazione delle pareti anteriori del rabdosfintere.

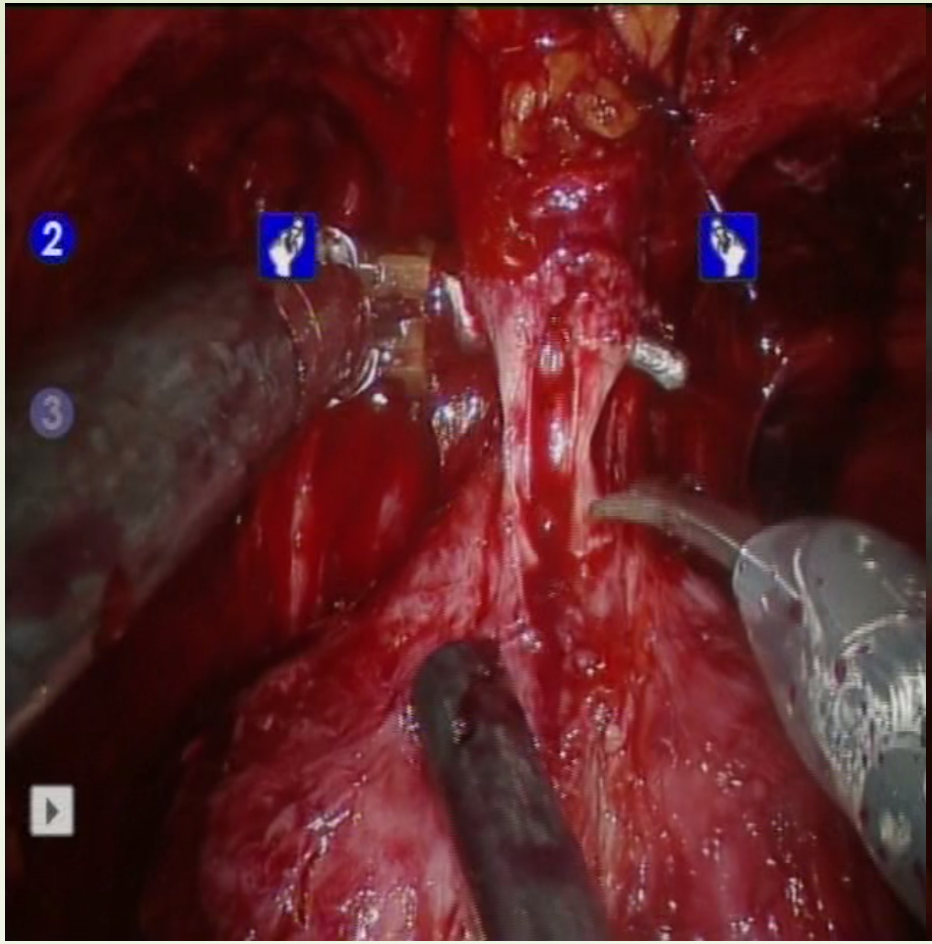
Fascia di Denonvilliers & Centro tendineo del perineo

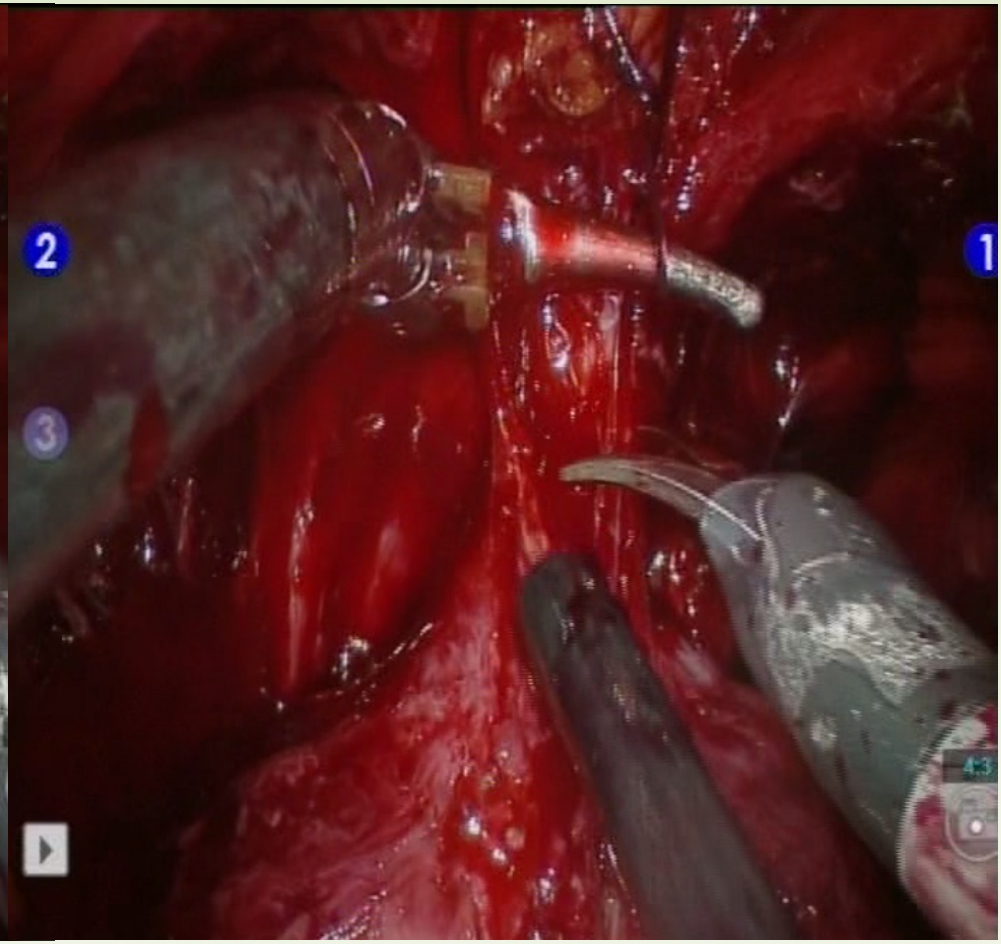


Rocco F et al. Eur Urol. 2007 Aug;52(2):376-83.

- PARTE DEL MUSCOLO VIENE SEZIONATO/DANNO TERMICO
- RIDUZIONE LUNGHEZZA DELL'URETRA MEMBRANOSA

➢ per ogni mm risparmiato, si riduce del 18% il tempo di recupero della continenza





FATTORI CHE MIGLIORANO IL RECUPERO DELLA CONTINENZA E DELLA POTENZA

- **PRESERVAZIONE COLLO VESCICALE**

Migliora la continenza a 3 mesi/Nessuna differenza a 6 e 12 mesi
(Lowe BA. Urology. Dec 1996 - Poon M. J Urol. Jan 2000. - Srougi J Urol. 2001)

- **TECNICA NERVE SPARING** (Burkhard J Urol 2006)

- **RICOSTRUZIONE POSTERIORE DEL RABDOSFINTERE**
  (Rocco F. J Urol 2006 – Rocco B. Eur Urol 2007)

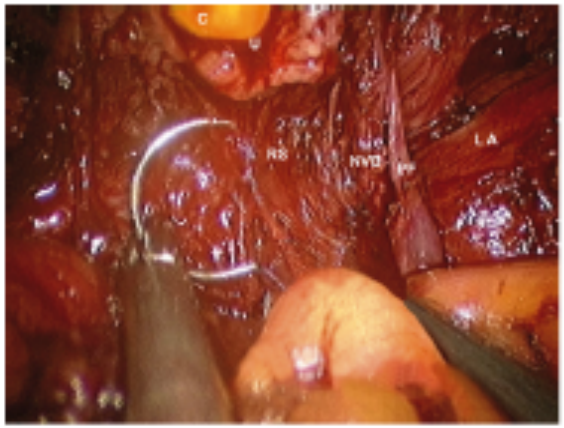
- **METICOLOSA DISSEZIONE DELL'APICE PROSTATICO**
  (Catalona et al, 2004)

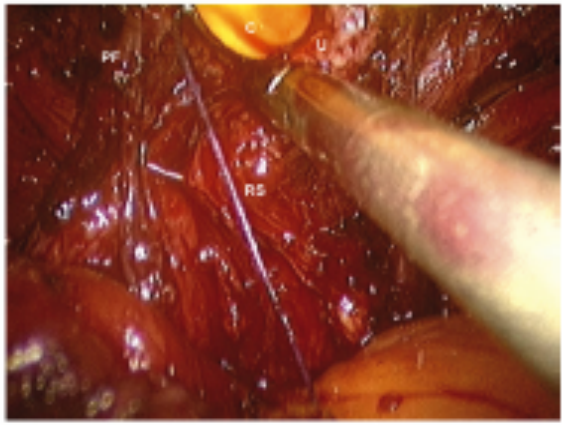
- **EVITARE DANNI DEL MONCONE URETRALE**
  (Walsh et al, 1992)

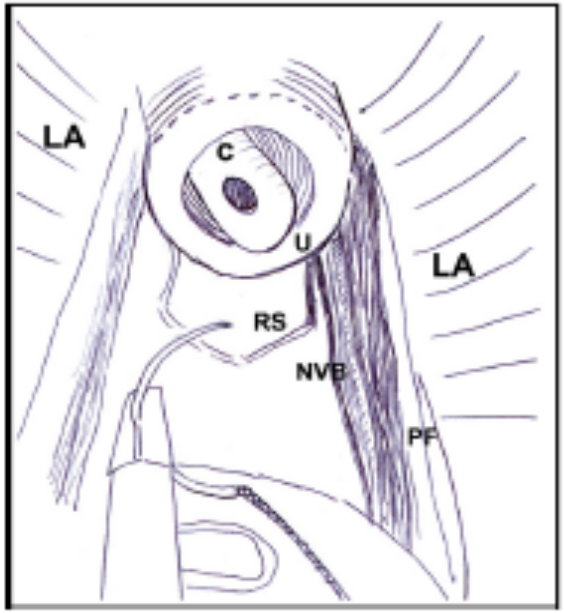
Posterior Reconstruction of the Rhabdosphincter Allows a Rapid Recovery of Continence after Transperitoneal Videolaparoscopic Radical Prostatectomy

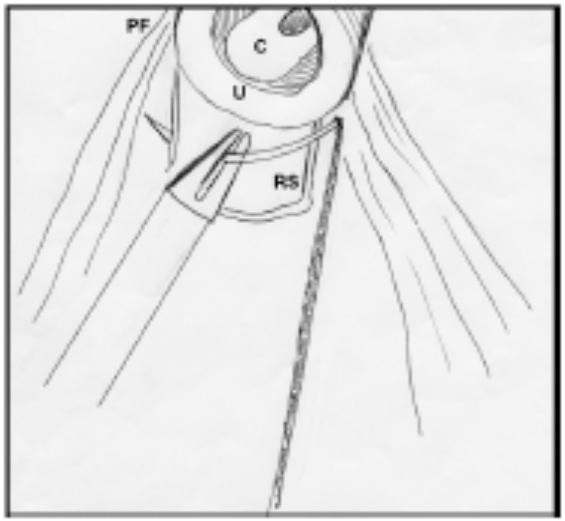
EUROPEAN UROLOGY 51 (2007) 996–1003

Bernardo Rocco[a], Andrea Gregori[b], Silvio Stener[b], Luigi Santoro[c], Andrea Bozzola[b], Stefano Galli[b], Roberto Knez[b], Francesco Scieri[b], Alessandra Scaburri[d], Franco Gaboardi[b,*]

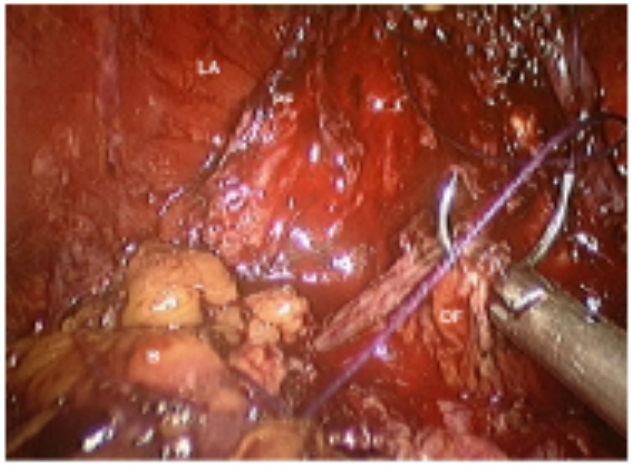








Figs. 1-2 – Placement of the first suture for the posterior reconstruction of the rhabdosphincter. It can be seen clearly that the suture does not involve the posterior portion of the urethra. C = catheter; LA = levator ani; NVB = neurovascular bundle; PF = prostatic fascia; RS = rhabdosphincter; U = urethra.



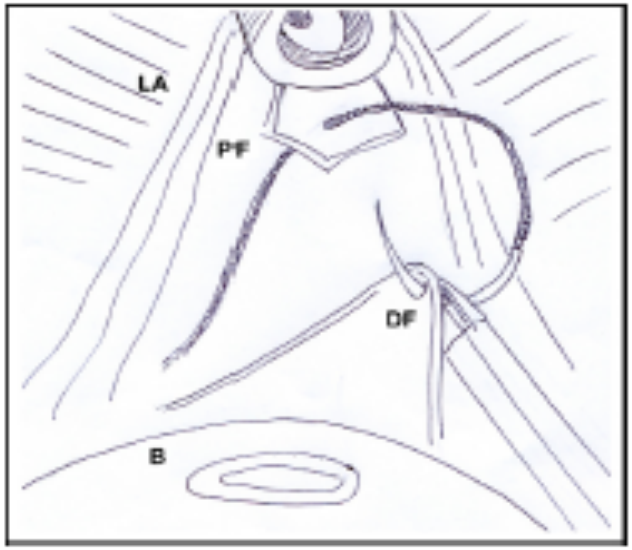


Fig. 3 – The suture is then passed through the remaining part of the Denonvilliers fascia. B = bladder; DF = Denonvilliers fascia LA = levator ani; PF = prostatic fascia.

Incontinenza urinaria

Systematic Review and Meta-analysis of Studies Reporting Urinary Continence Recovery After Robot-assisted Radical Prostatectomy

Ficarra et al. Eur Urol 62 (2012) 405-417

51 selected papers from January 1, 2008

- **PREVALENCE AND RISK FACTORS FOR URINARY INCONTINENCE POST-RARP**
  = no pad→ 12-mo urinary incontinence rates: mean value 16% (4%-31%)

- Increasing age
- BMI >30
- Prostate volume (cut-off value: 70-80 cm^3)
- Comorbidities
- LUTS severity
- Surgeon experience

Posterior Musculofascial Reconstruction After Radical Prostatectomy: A Systematic Review of the Literature

Rocco et al. Eur Urol 62 (2012) 779-790

11 selected papers from 2006

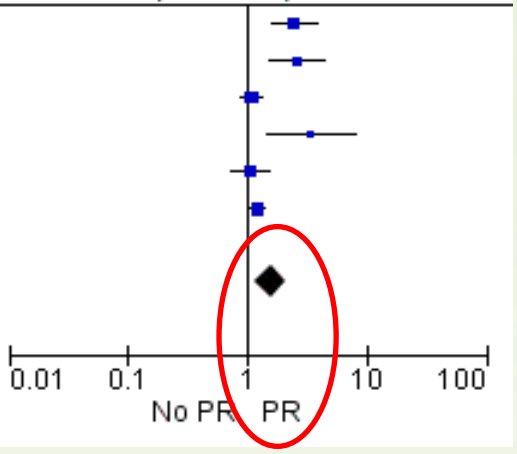
■ CONTINENCE

- Statistically significant IMPROVEMENT OF CONTINENCE at 3-7 d and 30-45 d from catheter removal
- Similar continence rates in patients with or without reconstruction at 90 d after RP

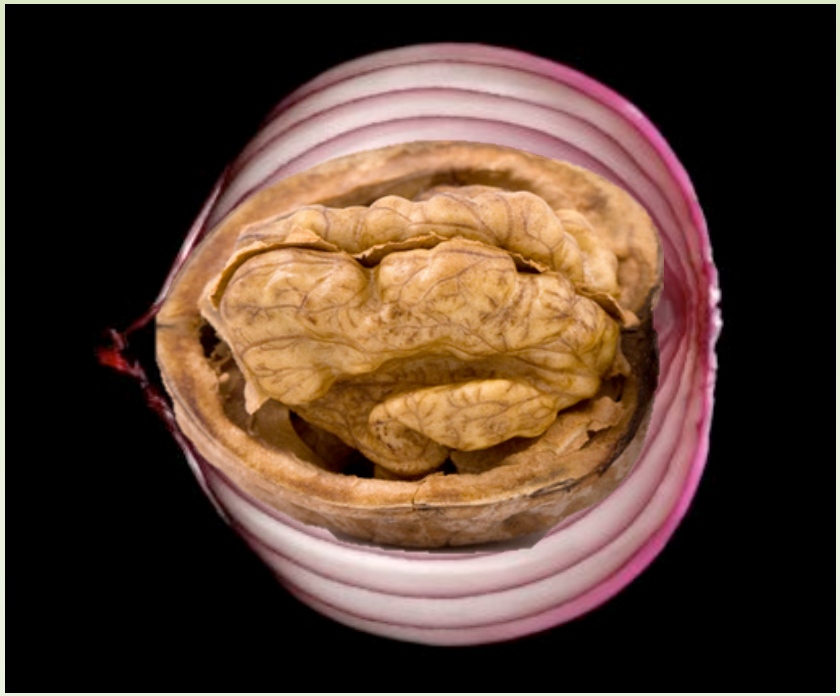
	PR		No PR			Risk Ratio		Risk Ratio
Study or Subgroup	**Events**	**Total**	**Events**	**Total**	**Weight**	**M-H, Random, 95% CI**	**Year**	**M-H, Random, 95% CI**
Rocco F Eur Urol 2007	185	250	15	50	16.2%	2.47 [1.61, 3.79]	2007	
Rocco B Eur Urol 2007	26	31	10	31	13.9%	2.60 [1.53, 4.43]	2007	
Menon J Urol 2008	47	59	42	57	21.4%	1.08 [0.88, 1.32]	2008	
Nguyen BJU 2008	18	32	5	30	8.4%	3.38 [1.43, 7.95]	2008	
Kim Yonsei Med J 2010	18	25	17	25	17.8%	1.06 [0.74, 1.52]	2010	
Coelho Eur Urol 2011	244	473	141	330	22.3%	1.21 [1.04, 1.41]	2011	
Total (95% CI)		**870**		**523**	**100.0%**	**1.57 [1.15, 2.14]**		
Total events	538		230					

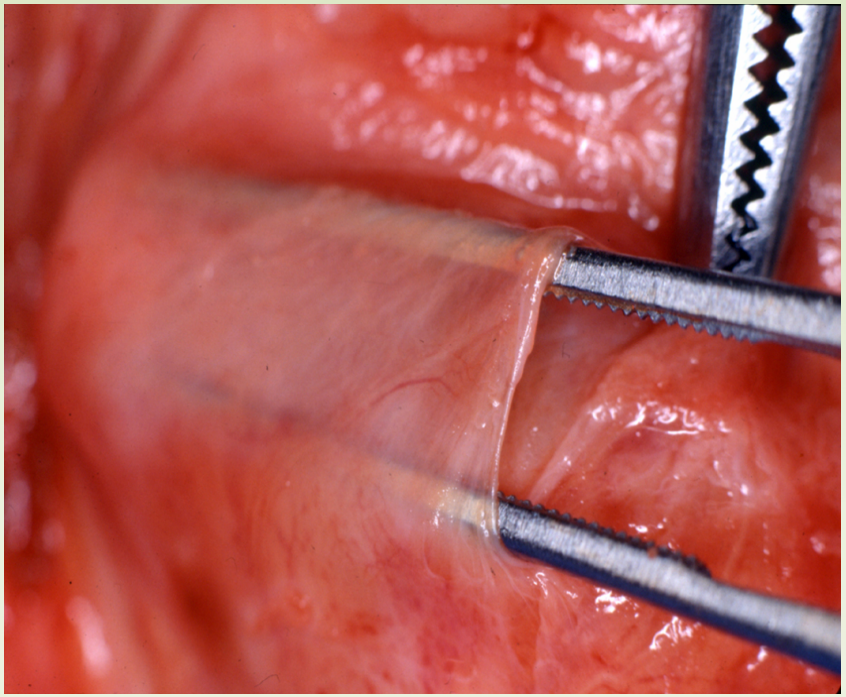
Heterogeneity: Tau² = 0.11; Chi² = 27.68, df = 5 (P < 0.0001); I² = 82%

Test for overall effect: Z = 2.85 (P = 0.004)



Neurovascular Bundle Anatomy





Prostate is like a walnut surrounded by few onion rings. Nerves are within the onion rings. Some times times cancer may be in the walnut peel or within the rings and we can not recognize these microscopic cells by magnification or touch. These layers are very delicate and quite complex with intermingling nerves.

M. Menon, A. Tewari

Neurovascular Bundle Anatomy

1982 - **Walsh e Donker**: descrivono il NVB come una struttura ben distinta sulla faccia posterolaterale della prostata.

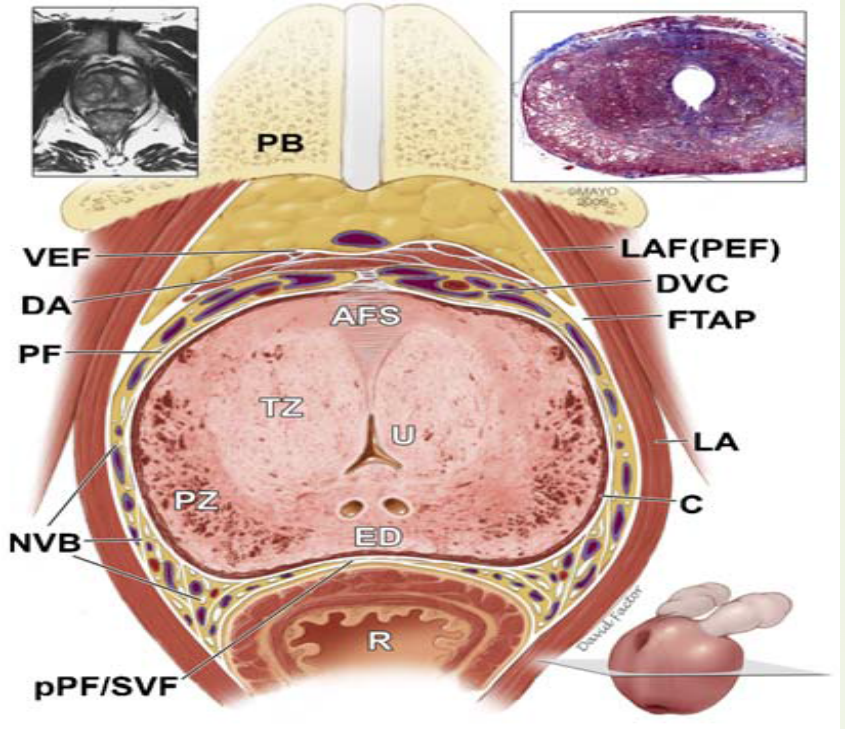
2004 - **Takenaka et al**: descrivono il NVB come un insieme di fibre disperse finemente.

2005 - **Lunacek et al**: hanno dimostrato come il NVB sia una struttura distinta durante la fase embriogenetica e come le fibre si disperdano durante lo sviluppo.

2/3 delle fibre superficie posterolaterale
1/3 delle fibre superficie anterolaterale

Distanza tra NVB e strutture anatomiche:

- 0 mm: vescicole seminali e base prostatica
- 4 mm: collo vescicale
- 2 mm: m. elevatore dell'ano
- 0-7 mm: peduncoli prostatici



Waltz et al, Eur Urol 2010

Anatomical studies of the neurovascular bundle and cavernosal nerves

2004 BJU INTERNATIONAL | 94, 1071-1076

ANTHONY J. COSTELLO, MATTHEW BROOKS and OWEN J. COLE

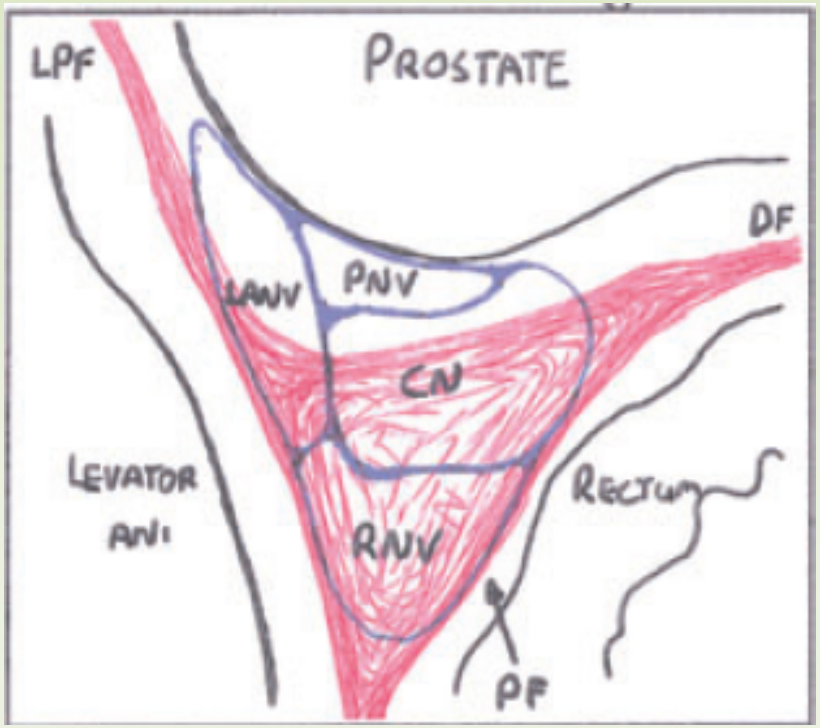
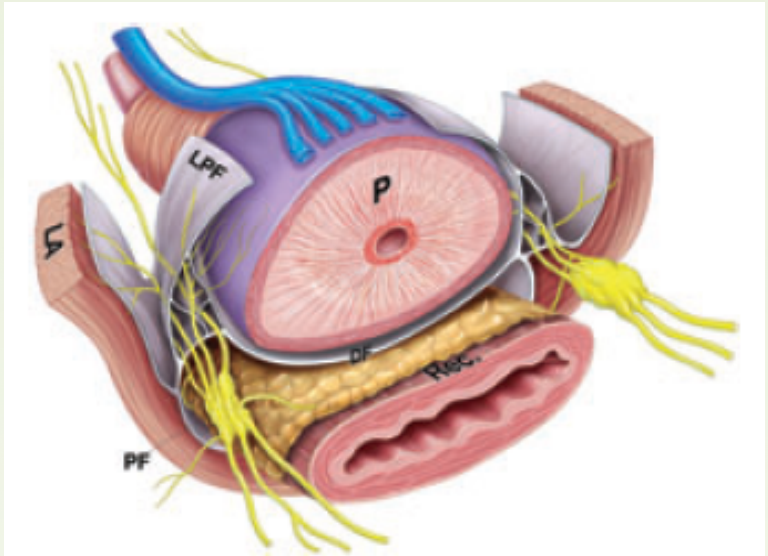


FIG. 9. Functional organization of the NVB; RNV, neurovascular supply to the rectum; DF, Denonvilliers' fascia; PF, pararectal fascia; LPF, lateral pelvic fascia; LANV, neurovascular supply to levator ani; PNV, neurovascular supply to the prostate; CN, cavernosal nerves.

NVB

- Starts at the base of the prostate between 3 and 9 o'clock.
- Travels outside the prostatic capsule, inferomedially to the apex.
- At the apex it projects anteriorly where it is most likely to be damaged at surgery



FATTORI CHE MIGLIORANO IL RECUPERO DELLA CONTINENZA E DELLA POTENZA

- **PRESERVAZIONE COLLO VESCICALE**

Migliora la continenza a 3 mesi/Nessuna differenza a 6 e 12 mesi
(Lowe BA. Urology. Dec 1996 - Poon M. J Urol. Jan 2000. - Srougi J Urol. 2001)

- **TECNICA NERVE SPARING** (Burkhard J Urol 2006)

- **RICOSTRUZIONE POSTERIORE DEL RABDOSFINTERE**
(Rocco F. J Urol 2006 – Rocco B. Eur Urol 2007)

- **METICOLOSA DISSEZIONE DELL'APICE PROSTATICO**
(Catalona et al, 2004)

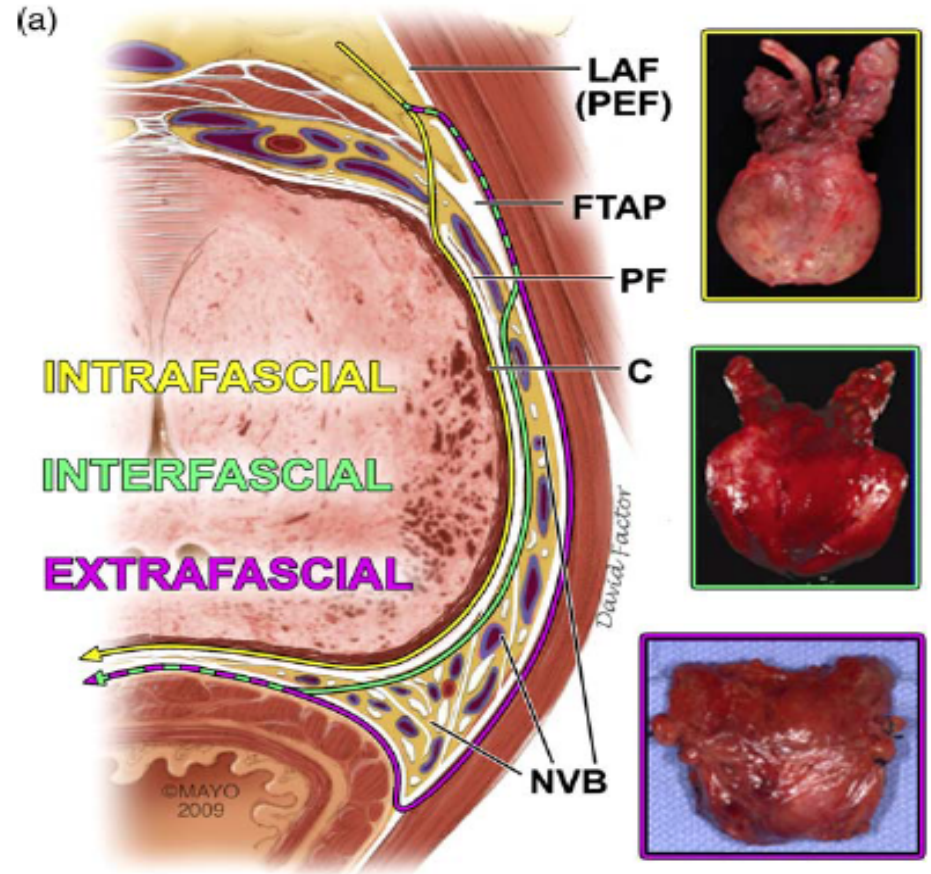
- **EVITARE DANNI DEL MONCONE URETRALE**
(Walsh et al, 1992)

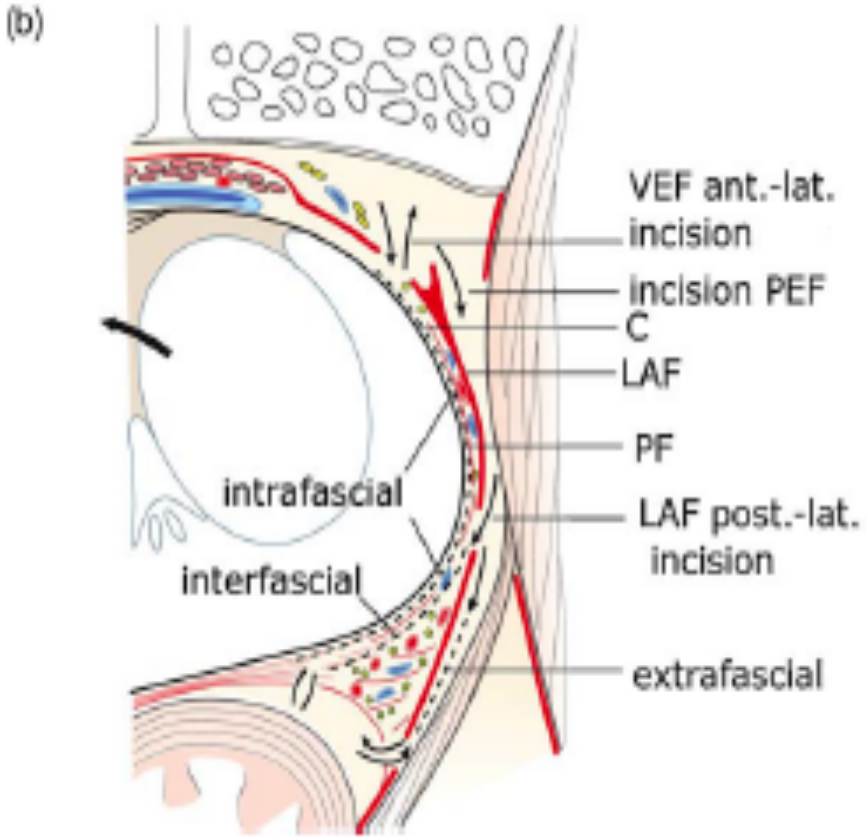
Planes of dissection

A Critical Analysis of the Current Knowledge of Surgical Anatomy Related to Optimization of Cancer Control and Preservation of Continence and Erection in Candidates for Radical Prostatectomy

Jochen Walz[a,*], Arthur L. Burnett[b], Anthony J. Costello[c], James A. Eastham[d], Markus Graefen[e], Bertrand Guillonneau[d], Mani Menon[f], Francesco Montorsi[g], Robert P. Myers[h], Bernardo Rocco[i], Arnauld Villers[j]

EUROPEAN UROLOGY 57 (2010) 179–192





Intrafascial → plane on the prostate capsule, medial to the prostatic fascia (PF) at the antero- and posterolateral aspect of the prostate and anterior to posterior prostatic fascia and seminal vesicles fascia

CONSENSUS PANEL PASADENA 2012

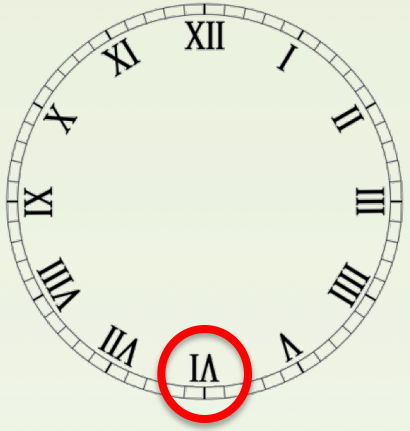
FULL NS

Tecnica del Velo di Afrodite

Capsula

Fascia prostatica

Fascia del m. elevatore dell'ano/ Fascia di Denonvilliers



Interfascial → lateral to the PF at the anterolateral and posterolateral aspects of the prostate combined with a dissection medial to the NVB at the 5 and 7 o'clock or 2 and 10 o'clock positions of the prostate in axial section

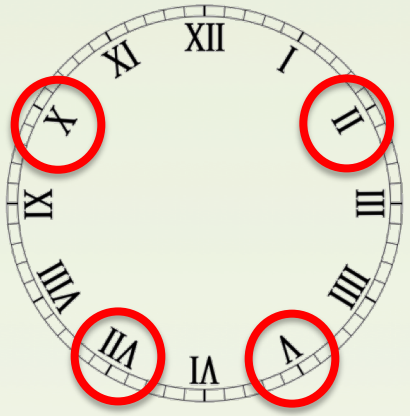
CONSENSUS PANEL PASADENA 2012

PARTIAL NS

Tecnica nerve sparing standard

Capsula

Fascia prostatica



Fascia del m. elevatore dell'ano/ Fascia di Denonvilliers

Extrafascial → lateral to the levator ani fascia and posterior to the posterior prostatic fascia and seminal vesicles fascia.

CONSENSUS PANEL PASADENA 2012

MINIMAL NS

Tecnica non nerve sparing

Capsula

Fascia prostatica

Fascia del m. elevatore dell'ano/ Fascia di Denonvilliers

Impotenza

Systematic Review and Meta-analysis of Studies Reporting Potency Rates After Robot-assisted Radical Prostatectomy

Ficarra et al. Eur Urol 62 (2012) 418-430

31 selected papers

- **PREVALENCE AND POTENTIAL RISK FACTORS OF ERECTILE DYSFUNCTION POST-nerve sparing RARP**

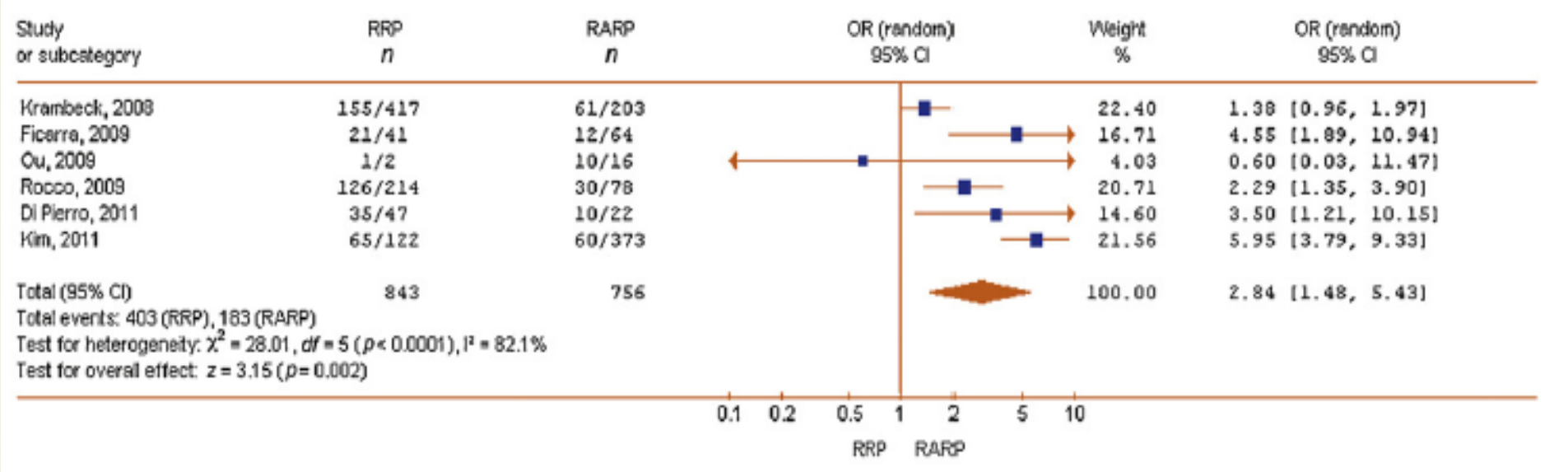
12-mo erectile dysfunction: 10%-46%
24-mo: 6%-37%

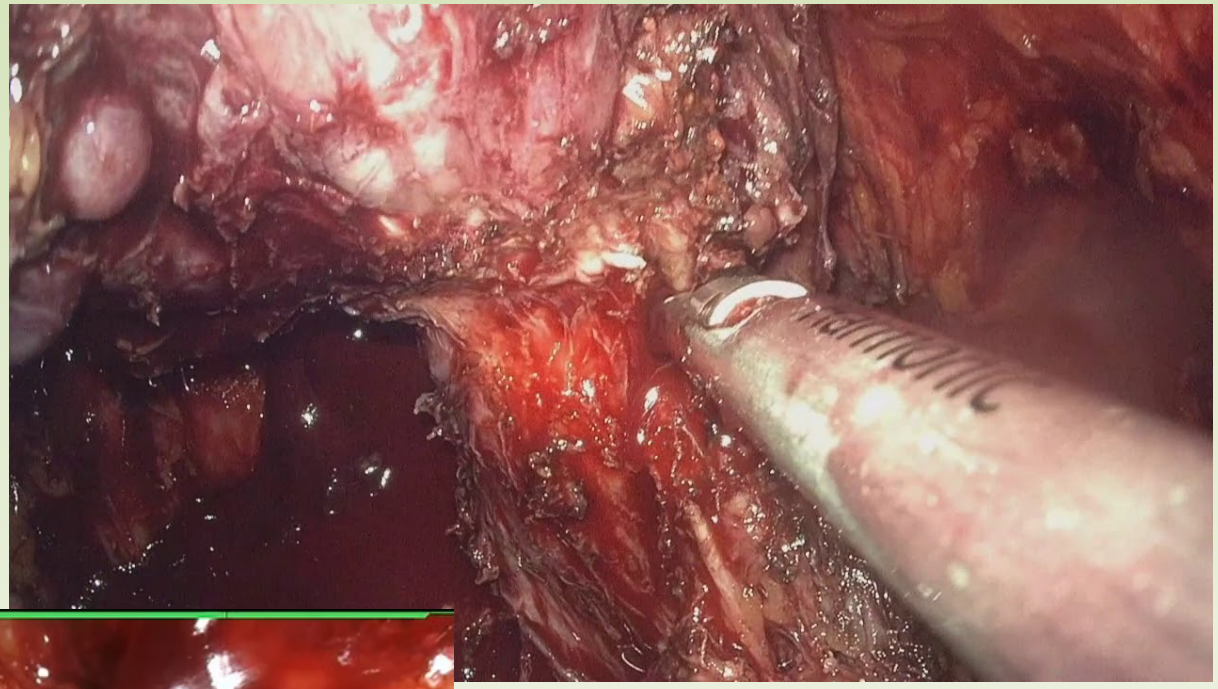
BUT definition of potency is a *non*standardized parameter

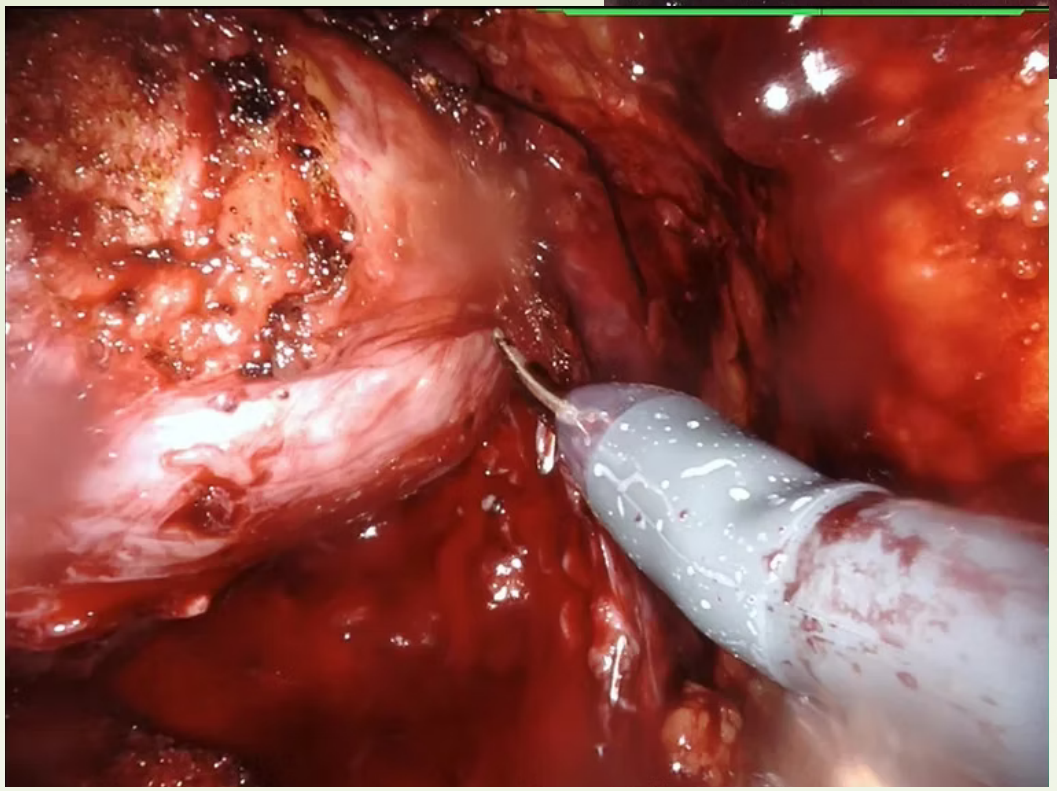
- Age at surgery
- Baseline erectile function
- Nerve-sparing extension and techniques

- **SURGICAL TECHNIQUES ABLE TO IMPROVE POTENCY RECOVERY**
  Interfascial VS intrafascial dissection: inconclusive results
  Athermal dissection: significant advantages in terms of early potency recovery

- COMPARISON BETWEEN RARP AND OTHER APPROACHES
  Significant ADVANTAGES for RARP in comparison with RRP in terms of 12-mo potency rates
  Non statistically significant trend in favor of RARP in comparison with LRP







European Urology

Combined Reporting of Cancer Control and Functional Results of Radical Prostatectomy☆

Laurent Salomon[a,*], Fabien Saint[a], Aristotelis G. Anastasiadis[b], Philippe Sebe[a], Dominique Chopin[a], Clément-Claude Abbou[a]

- 205 RP in un anno
- Punteggio complessivo in base a:
  - ✓ Risultato oncologico -BCR free- (da 0 a 4 punti)
  - ✓ Continenza (da 0 a 2 punti)
  - ✓ Erezione (da 0 a 1 punto)

TRIFECTA

Conclusioni

Questo punteggio consente la *valutazione globale* (controllo del cancro e funzionale) del *risultato chirurgico* nella prostatectomia radicale e faciliterebbe il confronto tra le diverse tecniche chirurgiche e i vari centri.

Systematic Review of Methods for Reporting Combined Outcomes After Radical Prostatectomy and Proposal of a Novel System: The Survival, Continence, and Potency (SCP) Classification

Vincenzo Ficarra[a,b,], Prasanna Sooriakumaran[c], Giacomo Novara[b], Oscar Schatloff[d], Alberto Briganti[e], Henk Van der Poel[f], Francesco Montorsi[e], Vip Patel[d], Ashutosh Tewari[c], Alexander Mottrie[a]*

Review sistematica per valutare criticamente i modelli Trifecta e Pentafecta e descrivere un nuovo sistema di classificazione

- Analizzati studi a partire dal 2003
- 11 articoli usavano il sistema Trifecta
- 1 articolo usava il sistema Pentafecta

Classificazione S C P

- S: Sopravvivenza libera da malattia
- C: Continenza
- P: Potenza

Pentafecta: A New Concept for Reporting Outcomes of Robot-Assisted Laparoscopic Radical Prostatectomy

Vipul R. Patel[a,], Ananthakrishnan Sivaraman[a], Rafael F. Coelho[a,b,c], Sanket Chauhan[a], Kenneth J. Palmer[a], Marcelo A. Orvieto[a], Ignacio Camacho[a], Geoff Coughlin[a], Bernardo Rocco[a,d]*

- BCR free
- Continenza
- Erezione

+

- Assenza di complicanze peri-operatorie
- Margini chirurgici negativi

=

PENTAFECTA

Conclusioni

Pentafecta *risponde più accuratamente alle aspettative del paziente* dopo intervento per il cancro alla prostata. Questo approccio può essere utile e deve essere usato durante il counselling dei pazienti con *malattia localizzata*.

TRIFECTA

SCP

PENTAFECTA

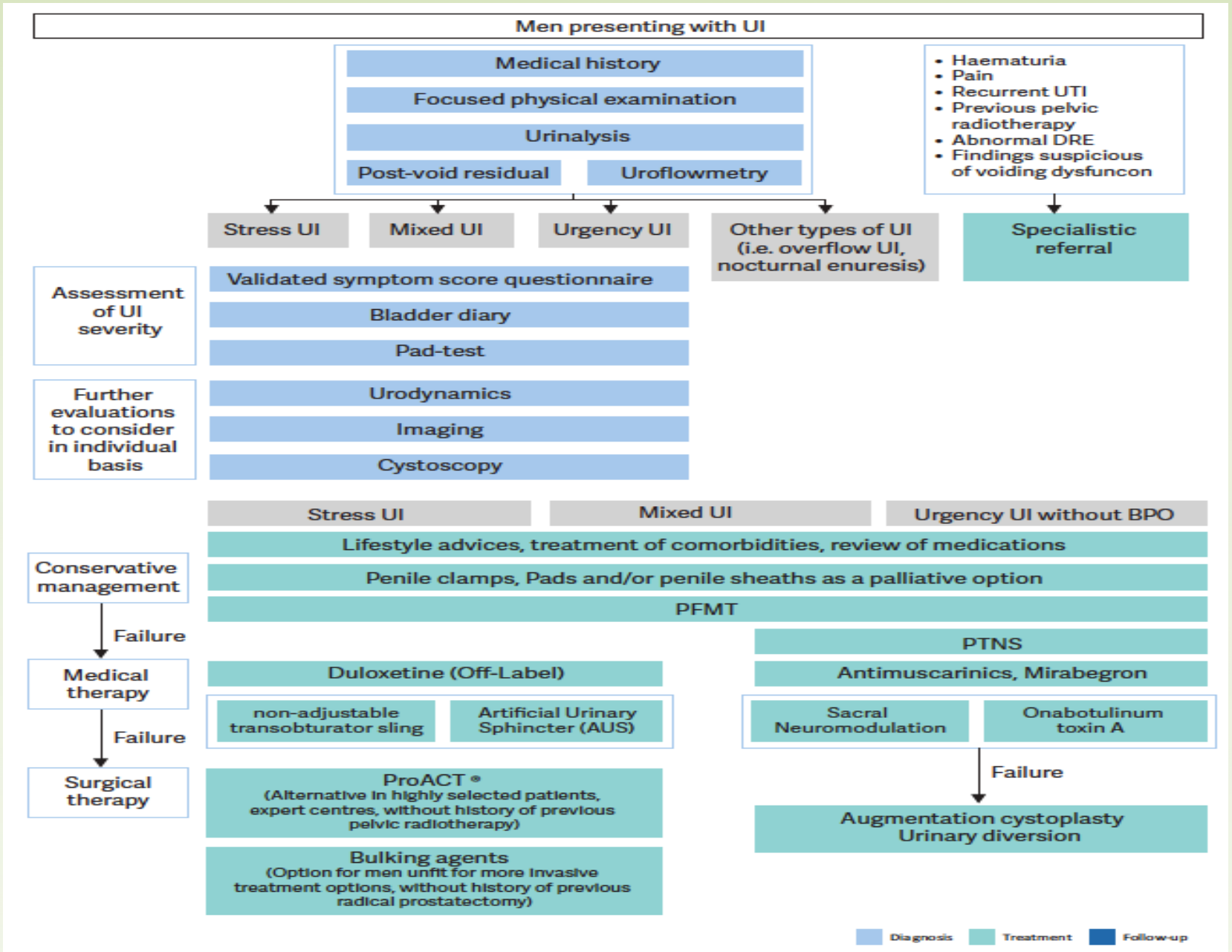
=

Buona QoL e recupero della normale vita sessuale?

Forse non bastano…

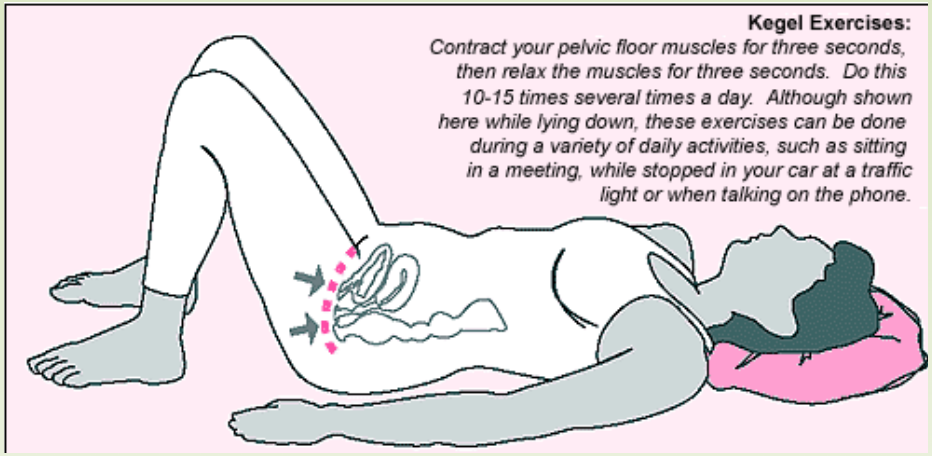
TRATTAMENTO RIABILITATIVO

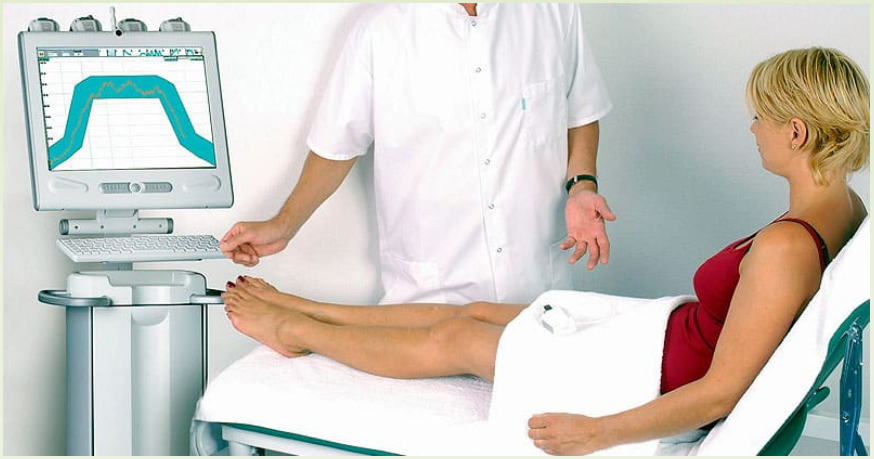
CONTINENZA



RIABILITAZIONE PELVI PERINEALE

- Biofeedback
- Stimolazione elettrica funzionale
- Pelvic floor muscle training (PMFT)





TERAPIA FARMACOLOGICA

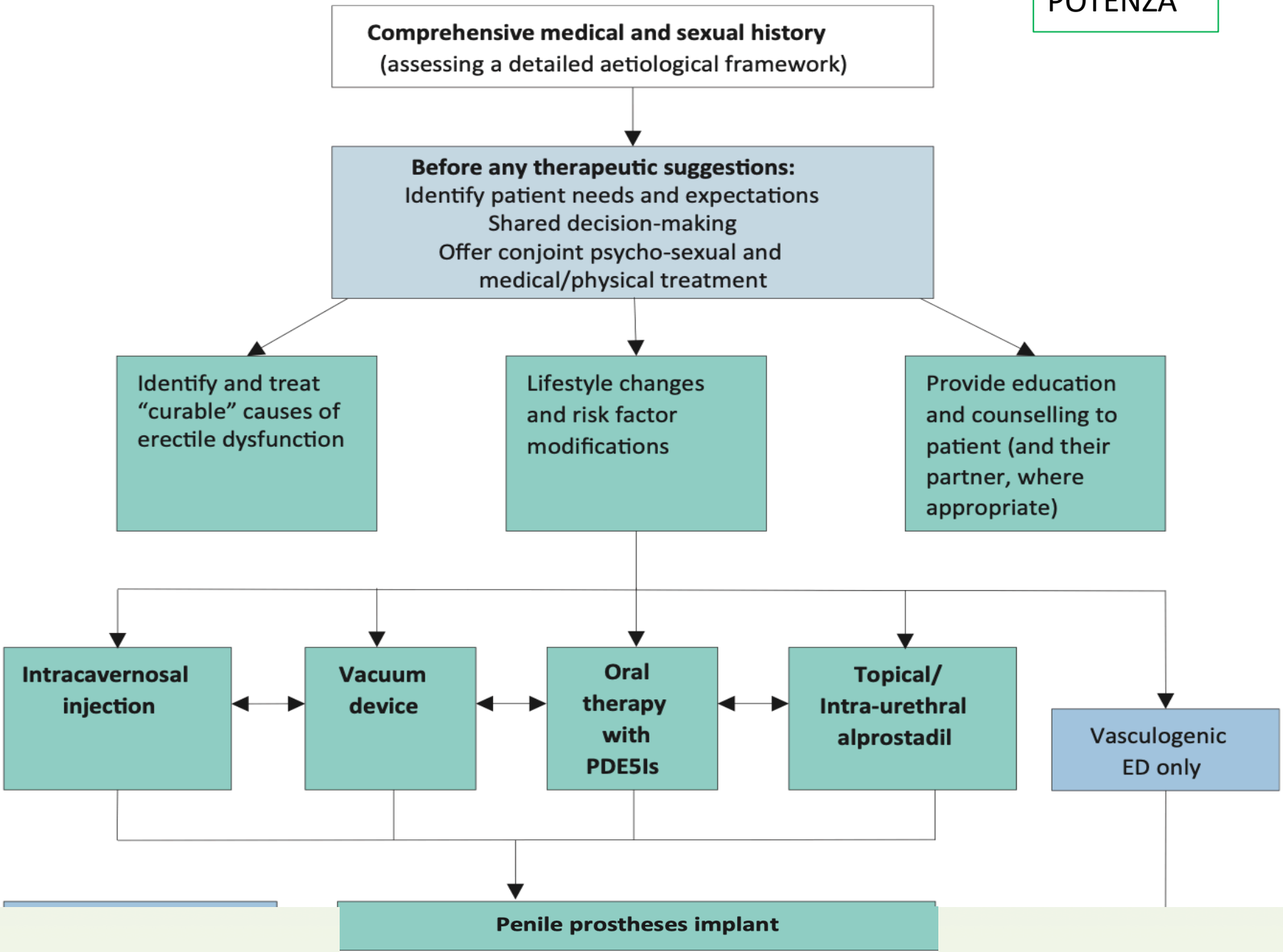
Duloxetina

TERAPIA CHIRURGICA

- Bulking Agents
- Sling: Invance, Advance, Modulabili
- Pro-Act
- Costrittore periuretrale
- Sfintere artificiale

Figure 5: Management algorithm for erectile dysfunction

POTENZA



- **Sildenafil**

- **Vardenafil**

- **Tadalafil**

- **Avanafil**

Inibitori PDE5

	Dose (mg)	T max (ore)	Emivita (ore)	Risultati (%)
sildenafil	25 50 100	0,5-2	2,6-3,7	63-84
vardenafil	5 10 20	0,25-3	4-5	60-80
tadalafil	10 20	0,5-5	17-46	61-80

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THE JOURNAL OF UROLOGY
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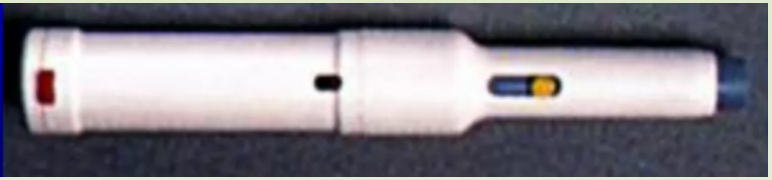
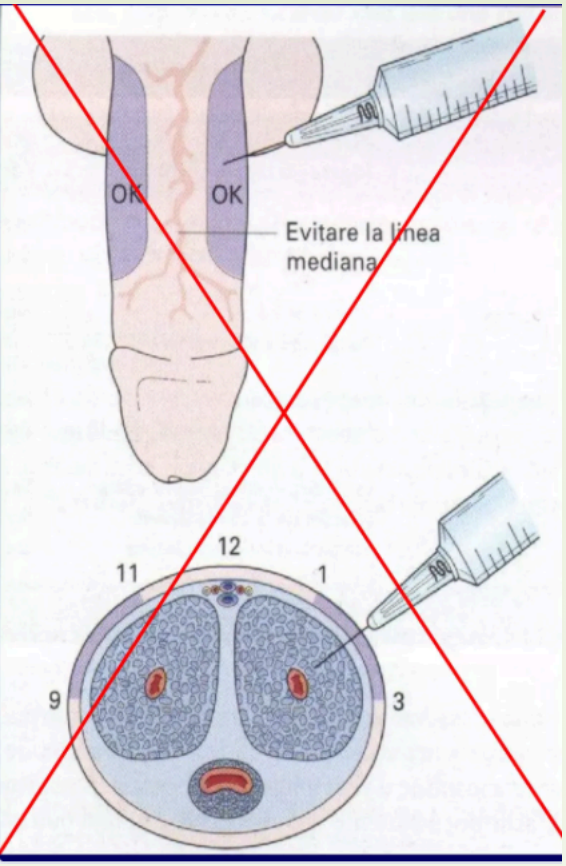
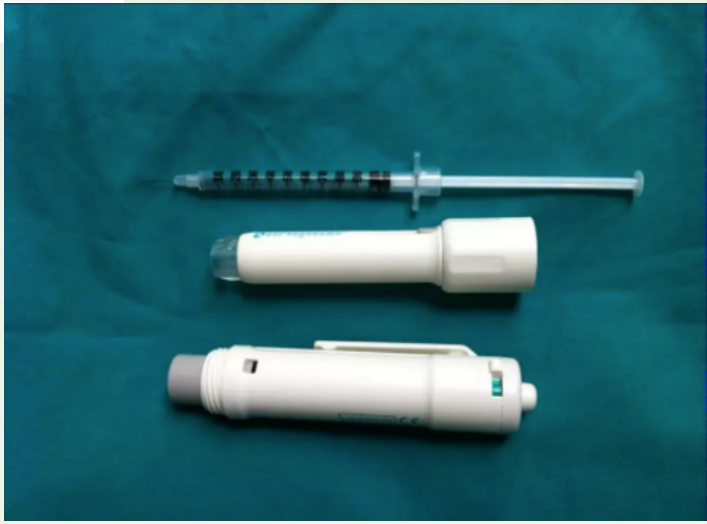
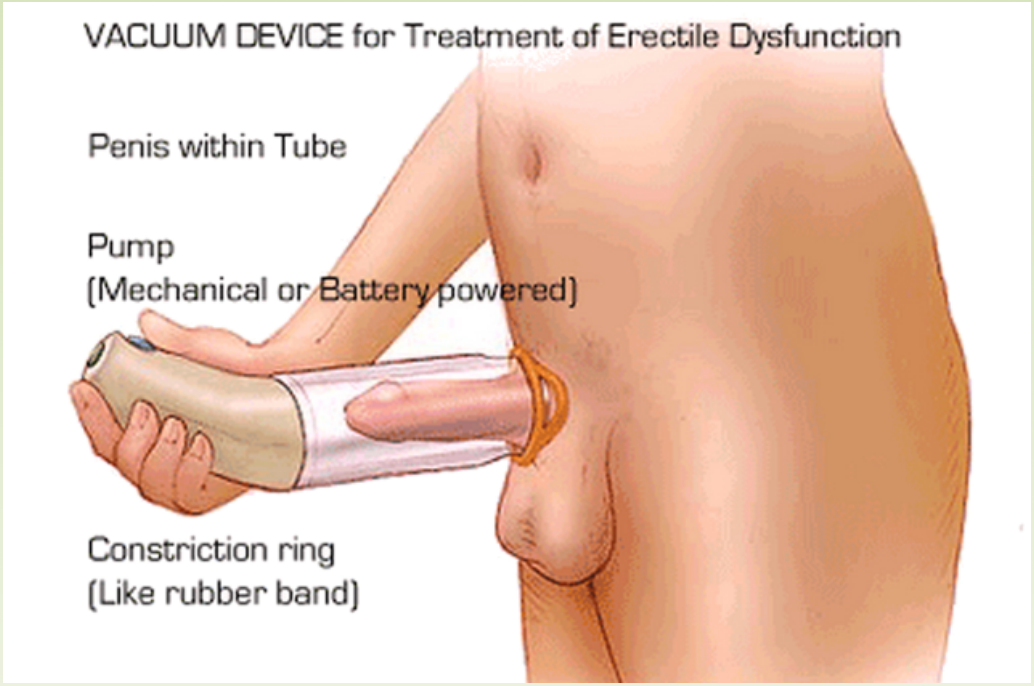
RECOVERY OF SPONTANEOUS ERECTILE FUNCTION AFTER NERVE-SPARING RADICAL RETROPUBIC PROSTATECTOMY WITH AND WITHOUT EARLY INTRACAVERNOUS INJECTIONS OF ALPROSTADIL: RESULTS OF A PROSPECTIVE, RANDOMIZED TRIAL





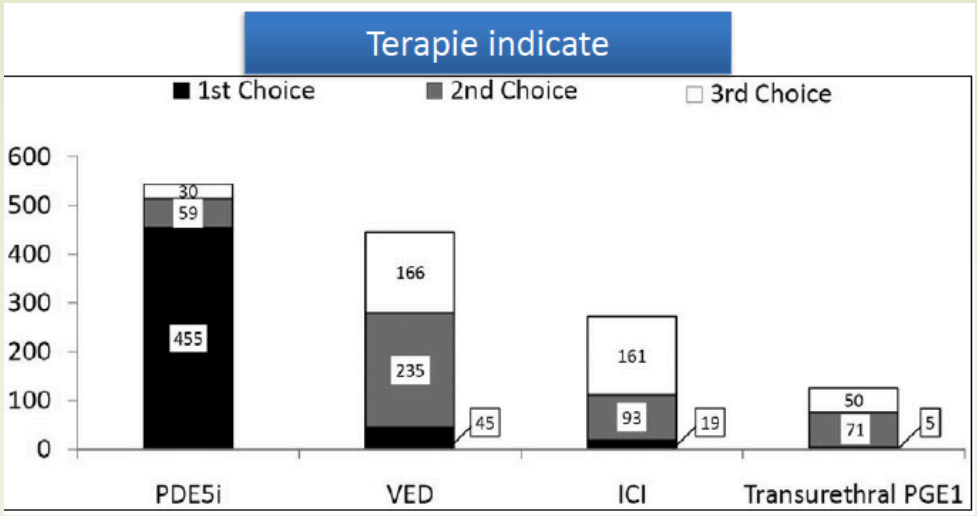


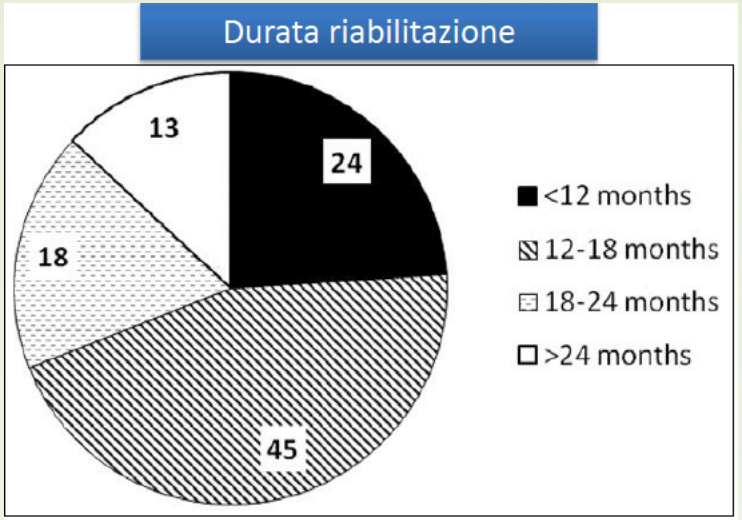

VACUUM DEVICE for Treatment of Erectile Dysfunction
Penis within Tube
Pump
(Mechanical or Battery powered)
Constriction ring
(Like rubber band)

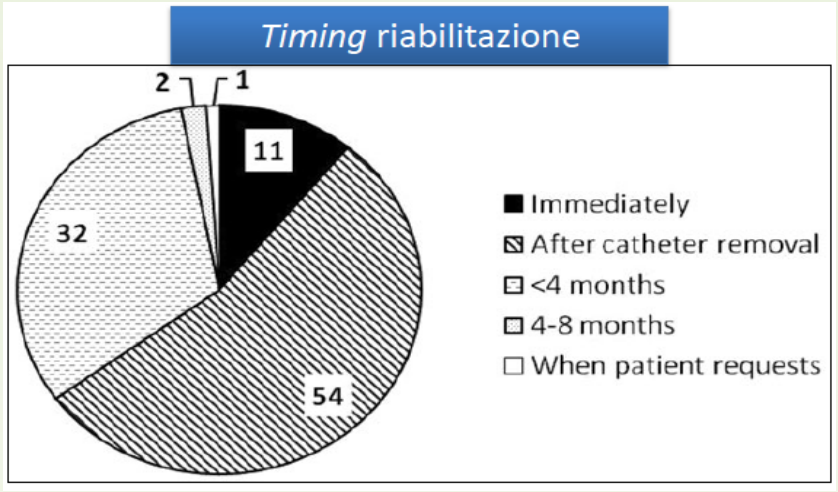

RELEASE
VACCUM
310 MM
70 MM


GLEITGEL
LUBRICANT
PRIMUS
PRIMUS
med

- Il precoce utilizzo di terapie può aiutare a prevenire l'ipossia tissutale
- La maggior parte degli urologi comincia la riabilitazione tra la rimozione del cv e i 2-3 mesi dall'intervento
- La continenza è un punto chiave per ottenere la compliance del pz alla riabilitazione andrologica



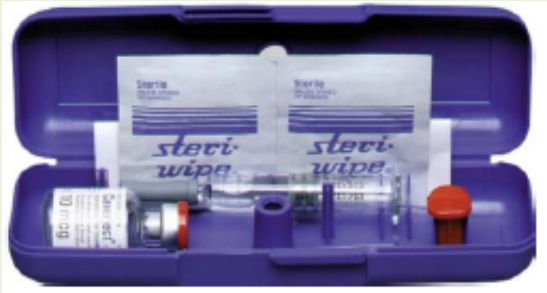




30% del volume totale	Indicazione alla chirurgia *nerve-sparing*
PDE5-I	100% (Tad 82%)
ICI	45.2%
ICI+PDE5-I	30%
Others (VCD, IUP)	24.2%

73.1 %	Inizia il programma alla rimozione del catetere
86.8%	Almeno per 12 mesi dall'intervento
51%	Riabilitazione ai pazienti non nerve-sparing

Quale paziente può essere considerato riabilitato?



RADICAL PROSTATECTOMY: LONG-TERM CANCER CONTROL AND RECOVERY OF SEXUAL AND URINARY FUNCTION ("TRIFECTA")

FERNANDO J. BIANCO, JR, PETER T. SCARDINO, AND JAMES A. EASTHAM

Predicting an Optimal Outcome After Radical Prostatectomy: The Trifecta Nomogram

James A. Eastham,* Peter T. Scardino and Michael W. Kattan

From the Division of Urology, Memorial Sloan-Kettering Cancer Center, New York, New York, and Department of Quantitative Health Sciences (MWK), Cleveland Clinic, Cleveland, Ohio

Evaluation of combined oncologic and functional outcomes after robotic-assisted laparoscopic extraperitoneal radical prostatectomy: Trifecta rate of achieving continence, potency and cancer control

Evanguelos Xylinas, M.D.*, Xavier Durand, M.D., Guillaume Ploussard, M.D., Alexandre Campeggi, M.D., Yves Allory, M.D., Ph.D., Dimitri Vordos, M.D., Andras Hoz

Prospective evaluation of combined oncological and functional outcomes after laparoscopic radical prostatectomy: trifecta rate of achieving continence, potency and cancer

s Allory, lomon

In nove studi si considera potente un paziente che abbia un'erezione sufficiente per un rapporto sessuale (ESI), con o senza l'uso di un inibitore della fosfodiesterasi di tipo 5

Preop Likeli Conti Analy Prostatectomy

Phillip M. Pierorazio, Benjamin A. Spencer, Tara R. McCann, James M. McKiernan, and Mitchell C. Benson

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Results of Radical Prostatectomy

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Trifecta Outcomes After Robotic-assisted Laparoscopic Prostatectomy

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Continence, potency and oncological outcomes after robotic-assisted radical prostatectomy: early trifecta results of a high-volume surgeon

Vipul R. Patel*, Rafael F. Coelho*†, Sanket Chauhan*, Marcelo A. Orvieto*, Kenneth J. Palmer*, Bernardo Rocco*†, Ananthakrishnan Sivaraman* and Geoff Coughlin*

Pentafecta: A New Concept for Reporting Outcomes of Robot-Assisted Laparoscopic Radical Prostatectomy

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