

PROSTATECTOMY IN A DISTRICT GENERAL HOSPITAL

Pages with reference to book, From 192 To 194

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Abstract

The result of 200 transvesical prostatectomies performed over a period of 3 years at the District Headquarter Hospital in Abbottabad are reviewed. The indications of operation were prostatism (28%), acute retention (64%) and chronic retention (8%). The mean stay in the Hospital was 14 days and mortality 2% (JPMA 37:192 , 1987).

INTRODUCTION

There was a time when open prostatectomy was considered a dangerous operation at District Headquarter Hospital level. This paper presents a retrospective study of 200 consecutive transvesical prostatectomies at an upgraded District Headquarter Hospital in Abbottabad between 1983 and 1985. These operations constituted 3.5% of all operations performed at this Hospital during the 3 year period.

PATIENTS MATERIAL AND METHODS

(a) Presentations:

The indications for surgery were:

- (i) Prostatism hesitancy, urgency, reduced stream, day time frequency and nocturia in 28% cases;
- (ii) acute urinary retention in 64% cases;
- (iii) chronic retention in 8%. Profuse haematuria was not a presenting feature.

(b) Evaluation of Patient:

Preliminary assessment included careful history, general, cardio-pulmonary examination as well as rectal examination, urine analysis, haemoglobin and complete blood count, blood urea, blood sugar and chest and abdominal X-rays (KUB). Serum acid phosphatase, urine culture and intravenous pyelogram were done when necessary. Four patients were diabetic. In 56 patients (28%) blood urea was greater than 40 mg/dl and, in six, greater than 100 mg/dl. The haemoglobin ranged between 9.8 and 14.0 g/dl. Age ranged between 50 and 80 years, and eighty percent of these patients were in their sixties.

(c) Surgical Procedure:

Either a transvesical prostatectomy (n1 74) or wedge excision of the bladder neck (n=26) was performed under general anaesthesia. A No. 24 Foley catheter was inserted per urethra and the bladder was closed around an intravesical tube. Continuous irrigation with normal saline was done routinely. On average 30 litres were needed. On the 3rd day suprapubic tube was removed. Four patients who bled unduly at operations had their prostatic cavities packed with gauze. Postoperatively co-trimazole injection B.D. (100 patients) or ampiclox 500 mg 8 hourly (100 patients) were used for 7 days. Eighty percent patients were transfused two pints of blood, 5% needed more than 2 pints of blood and 11% needed one pint of blood. In 4% blood was not needed. Sixty five per cent patients were discharged on 8th post-operative day. The remaining 35% were discharged between 14th day to 21st day.

(d) Associated conditions:

Twenty-two (11%) patients had associated intravesical stones, 14 patients (7%) had carcinoma of the prostate confirmed histologically; two (1%) had transitional cell bladder carcinoma and were subjected to radiotherapy.

(e) Complications: (Table-I)

TABLE – I
Morbidity

	No. of cases
Reactionary haemorrhage	5
Secondary haemorrhage	30
Clot retention	20
Supra-pubic leakage	54
Epididymo-orchitis	6
Wound infection	38
Stricture	14
Osteitis pubis	2
Scrotal swelling	2

Fifty four patients (27%) developed suprapubic leakage due to which their hospitalisation was prolonged. These were treated conservatively by an indwelling urethral catheter. Thirty eight patients (19%) developed wound infection due to E.Coli (12%) and proteus (7%). Severe post-operative haemorrhage was seen in 5 (2.5%) patients who had to be re-explored and their prostatic cavities packed with gauze. Mild secondary haemorrhage occurred on 5th to 7th days in some cases which was treated with bladder wash and change of antibiotic. Acute epididymo-orchitis was present in only 6 (3%) patients who settled with antibiotics. Occasionally patients developed this complication more than a month after operation. Postoperative urinary incontinence was also seen which invariably disappeared within a few days. No patient was permanently incontinent. Stricture of the urethra developed in 7% of the patients. Osteitis pubis developed in 2 (1%) patients within 1-12 weeks of the operation, necessitating removal of sequestrum in one patient.

(f) Mortality:

Four patients died within 30 days of operation from cardio-respiratory disease.

DISCUSSION

The advantage of transvesical prostatectomy is that secondary or incidental changes, e.g., bladder stones, diverticulae and cancers may be dealt with synchronously. Cystoscopy which is routine in retropubic prostatectomy is usually not required¹.

Transurethral prostatectomy is not yet developed in our hospital; even in special centres the open operation is often preferred for exceptionally large gland and when there are associated large bladder stones or diverticulae. Transvesical prostatectomy in our experience is safe and easy. The safety of the operation is the result of a better understanding of the disease, improved laboratory facilities, safer anaesthesia, more efficient postoperative care, antibiotics and blood transfusion. The low mortality in the present series compares favourably with other published series²⁻⁴. The morbidity was high and may be attributed to prolonged and improper catheterisation before operation and lack of control of infection.

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