RETROPUBIC PROSTATECTOMY.

The three established routes of access to the obstructing prostate, namely, the suprapubic, the perineal and the transurethral would appear to have left no scope for yet another method of operative approach to the gland. Terence Millin (1945), however, has recently described a fourth, the retropubic and claims for his operation not only a low mortality but also an absence of the variable difficulties, complications and post-operative discomforts that may beset the other three methods, as well as a brief confinement to bed and a rapid convalescence.

The usual preliminary tests of renal and cardio-vascular function are made, the author laying particular stress on intravenous urography. Preliminary urethral catheter drainage is used only when retention has supervened, when the renal functional tests reveal a marked deficiency and when there is a urinary infection that does not respond to appropriate antiseptics.

The operative technic is as follows. With the bladder emptied, a mid-line incision is made from a point over the pubis and extending upwards for two and a half to three inches. The aponeurosis is incised and the recti separated in the middle line. The retropubic fat and peritoneal fold are swept upwards and a self-retaining retractor is introduced which will keep the recti widely separated and the bladder pressed upwards and backwards. With the retropubic space thus exposed and adequately illuminated, the veins situated in the endopelvic fascia, which course upwards on the anterior and lateral aspects of the prostate, are in turn underrun with the boomerang needle and ligatured. The anterior and lateral aspects of the gland are cleared of all overlying adherent fat; and bleeding from any torn veins which may occur in the process, is controlled by prompt seizure with haemostats, and the application of diathermy. A curved incision, convex downwards, one centimetre distal to the bladder neck is made through the prevesical fascia and true prostatic capsule. Bleeding vessels in the lower flap are grasped with forceps and the flap is undermined towards the apex of the gland. The underlying false capsule is now incised by an inverted V incision, thus exposing the adenoma. The lower margins of the lateral lobes are freed with closed scissors and the enucleation continued with the finger working from below upwards until both lateral lobes and the middle lobe when present, are delivered into the wound, though still attached to the bladder neck. The pedicle on each side is seized with forceps and the adenomatous mass detached with scissors or diathermy needle. A No. 18 Harris catheter is passed along the urethra and guided into the bladder and the defect in the false capsule closed with a continuous suture of No. 0
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catgut, using the boomerang needle. The true capsule is then approximated over this with three or more interrupted No. 0 catgut sutures. With all obvious bleeding points now controlled, the field is sprayed with sulphanilamide powder, a small corrugated drain is placed down to the suture line and the rectus sheath and skin closed. The catheter is irrigated with 1/5,000 flavine to free it from any clot and four ounces of the fluid is left in the bladder. A length of sterile tubing is attached to the catheter with a glass connection of even bore, the lower end of the tubing being spigoted. Millin claims that the operating time need not exceed half an hour and is often nearer 20 minutes.

The postoperative treatment is on the simplest lines. Two hours after the patient’s return to bed, the spigot is released and the tubing placed in a bottle by the bedside. Only in the exceptional case is any postoperative syringing of the catheter necessary for there is remarkably little bleeding. A sanguinous ooze drains through the lower end of the wound during the first twelve to thirty-six hours. The drain at this site is removed on the third or fourth day and the catheter on the sixth or seventh day. The patient is encouraged to get up on the fourth day and is usually ready to leave hospital in fourteen days.

The Lancet’s accompanying editorial comment paid high tribute to this new operation as being ‘simpler, safer and better than those now in use’ and because ‘it seems to avoid the dangers and discomforts of the transvesical, the disasters of the perineal and the sequelae of the perurethral operations and bids fair to supplant them all.’ These opinions, as well as that of Millin that his operation represents a great advance in the treatment of prostatic obstruction, are questioned by several correspondents in subsequent issues of the Lancet. Although there is a natural reluctance to relinquish well-tried operative procedures, a new method for the removal of prostatic obstruction which offers such high promise cannot be neglected. Since the details of the operation were first published Jacobs (1946) has employed it on twenty-three occasions. He is of the opinion that the claims made for it are fully justified and that the method is destined to occupy an important place in the treatment of the obstructing prostate, though it will not necessarily displace all previous methods. It seems probable, for example, that transurethral resection will remain the method of choice for removing the obstructing fibrous prostate and also, of course, for the relief of retention in cases of prostatic carcinoma. When gross renal damage or pronounced cardiovascular disease limits operative intervention to a suprapubic cystostomy, a high opening should be established. The further away this is placed from the symphysis, the easier will it be to make a retropubic exposure, should the patient’s subsequent improvement be such as to warrant a second stage prostatectomy.

REFERENCES.
Millin, T. (1945), Lancet 2: 693.
Jacobs, A. (1946), Personal communication.