



BULBO-PROSTATIC URETHROPLASTY

Information about your procedure from
The British Association of Urological Surgeons (BAUS)

This leaflet contains evidence-based information about your proposed urological procedure. We have consulted specialist surgeons during its preparation, so that it represents best practice in UK urology. You should use it in addition to any advice already given to you.

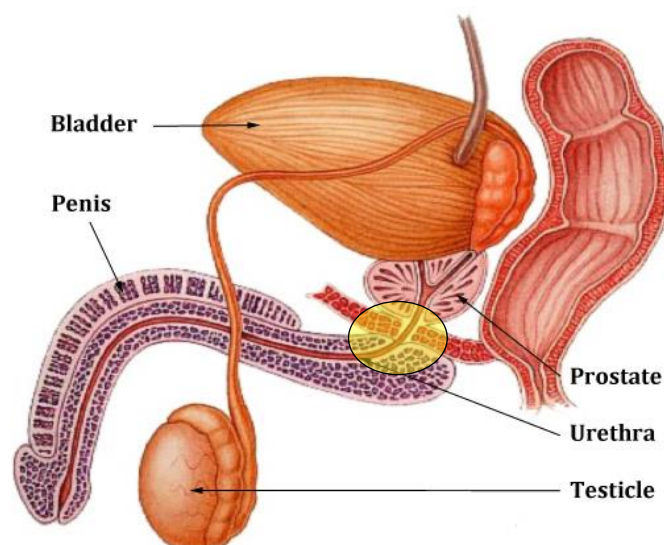
Further, general information about strictures can be found in the leaflet [Urethral Stricture Disease](#).

To view the online version of this leaflet, type the text below into your web browser:

http://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Bulbo-prostatic_urethroplasty.pdf

Key Points

- The bulbo-prostatic urethra (circled below) is prone to injury by pelvic fractures but can usually be repaired once all other associated injuries have settled
- Sexual dysfunction is common after pelvic fractures and can be made worse by reconstructive surgery
- Intensive investigation may be needed before reconstructive surgery is undertaken
- Urethral & suprapubic catheters may be left in after surgery
- All bulbo-prostatic urethroplasties will take place in specialist supra-regional centres



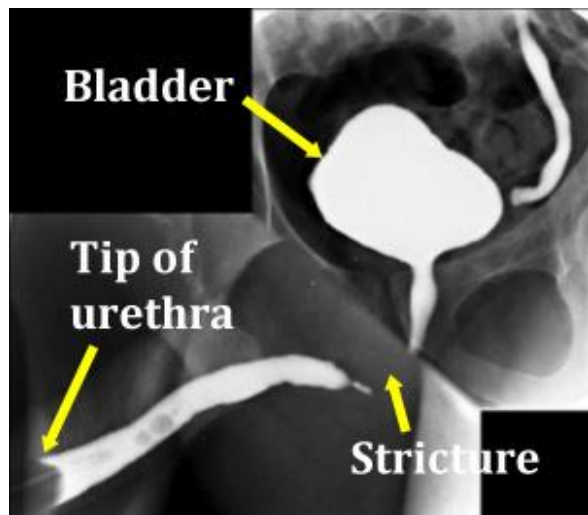
What does this procedure involve?

The urethra (waterpipe) can be completely torn by a pelvic fracture. In this case, there is no connection between your urethra and bladder. You will usually have a suprapubic catheter (a catheter in your tummy) put in soon after your injury to allow bladder drainage. The separation between your bladder and urethra is usually just below the prostate (**the membranous urethra**) where the muscles responsible for continence are attached.

The aim of reconstruction is to re-join the two torn urethral ends. After the reconstruction, your continence is maintained by a ring of muscle at the bladder neck because the main sphincter (valve) mechanism has been irreparably damaged by the pelvic fracture.

If you have had previous surgery on, or an injury to the bladder neck, you are much more likely to be incontinent after a reconstruction. In this case, your surgeon will discuss options such as [insertion of an artificial urinary sphincter \(AUS\)](#) as a later procedure to help your incontinence.

Before agreeing to have the procedure, you may be asked to have a urethrogram (pictured). This is an X-ray that shows all your urethra and assesses the length of the stricture. It is done by placing a very fine catheter inside the tip of the urethra and injecting contrast medium (a dye that shows up on X-ray) whilst X-rays are taken.



We often put contrast medium into the bladder through your supra-pubic catheter as well. You may be asked to try and pass urine once the bladder has been filled. This helps us to understand the length and complexity of the urethral injury. If the X-rays do not show the length of the stricture clearly, a telescopic examination through the suprapubic catheter site may be performed.

What are the alternatives?

- **Observation** – with a long-term suprapubic catheter
- [Urinary diversion](#) - into a bowel segment (ileal conduit) so that urine is collected in a bag

What happens on the day of the procedure?

Your urologist (or a member of their team) will briefly review your history and medications, and will discuss the surgery again with you to confirm your consent.

An anaesthetist will see you to discuss the options of a general anaesthetic or spinal anaesthetic. The anaesthetist will also discuss pain relief after the procedure with you.











We may provide you with a pair of TED stockings to wear, and give you a heparin injection to thin your blood. These help to prevent blood clots from developing and passing into your lungs. Your medical team will decide whether you need to continue these after you go home.

Details of the procedure

- we usually carry out the procedure under a general anaesthetic
- we usually give you an injection of antibiotics before the procedure, after you have been checked carefully for any allergies
- we normally make an incision in your perineum (between the back of your scrotum and your anus); occasionally, we need to make an incision in your lower abdomen as well
- we identify the ends of your urethra and remove the scar tissue until healthy tissues are found at each end
- we may need to re-route the urethra by removing a piece of cartilage or bone from the back of your symphysis pubis (the front of your pelvis)
- we sew the healthy ends of the urethra back together over a catheter
- we close the skin with dissolvable stitches
- we usually put in a temporary drain
- we put a catheter into your bladder through your urethra; this needs to remain for one to two weeks & we may remove your suprapubic catheter at this stage
- the procedure takes two to three hours to perform
- you should expect to be in hospital one to two nights

Are there any after-effects?

The possible after-effects and your risk of getting them are shown below. Some are self-limiting or reversible, but others are not. We have not listed very rare after-effects (occurring in less than 1 in 250 patients) individually. The impact of these after-effects can vary a lot from patient to patient; you should ask your surgeon's advice about the risks and their impact on you as an individual:

After-effect	Risk
Swelling & bruising of the wound site	 Between 1 in 2 & 1 in 10 patients
Recurrent stricture formation requiring further surgery or other treatment	 Between 1 in 2 & 1 in 10 patients
Erectile dysfunction requiring further treatment after the procedure	 Between 1 in 2 & 1 in 10 patients
Wound or urinary infection requiring antibiotics	 Between 1 in 10 & 1 in 50 patients
Urinary incontinence due to sphincter weakness or bladder overactivity (due to nerve damage caused by the pelvic fracture)	 Between 1 in 10 & 1 in 50 patients
Failure of the urethra to join completely resulting in urine leakage around the stitch line (fistula)	 Between 1 in 10 & 1 in 50 patients
Delayed bleeding requiring removal of clots or further surgery	 Between 1 in 50 & 1 in 250 patients
Wound breakdown requiring further surgery	 Between 1 in 50 & 1 in 250 patients
Anaesthetic or cardiovascular problems possibly requiring intensive care (including chest infection, pulmonary embolus, stroke, deep vein thrombosis, heart attack and death)	 Between 1 in 50 & 1 in 250 patients (your anaesthetist can estimate your individual risk)
Rectal injury (damage to your back passage) during the urethral procedure	 Between 1 in 50 & 1 in 250 patients

What is my risk of a hospital-acquired infection?

Your risk of getting an infection in hospital is approximately 8 in 100 (8%); this includes getting *MRSA* or a *Clostridium difficile* bowel infection. This figure is higher if you are in a “high-risk” group of patients such as patients who have had:

- long-term drainage tubes (e.g. catheters);
- bladder removal;
- long hospital stays; or
- multiple hospital admissions.

What can I expect when I get home?

- you will be given advice about your recovery at home
- you will be shown how to manage your catheter
- arrangements will be made for catheter supplies to be delivered to you, if required
- a date and venue for your catheter removal will be arranged
- you will be given a copy of your discharge summary and a copy will also be sent to your GP
- any antibiotics or tablets you may need will be arranged & dispensed from the hospital pharmacy
- a follow-up appointment will be arranged

General information about surgical procedures

Before your procedure

Please tell a member of the medical team if you have:

- an implanted foreign body (stent, joint replacement, pacemaker, heart valve, blood vessel graft);
- a regular prescription for a blood thinning agent (warfarin, aspirin, clopidogrel, rivaroxaban or dabigatran);
- a present or previous *MRSA* infection; or
- a high risk of variant-CJD (e.g. if you have had a corneal transplant, a neurosurgical dural transplant or human growth hormone treatment).

Questions you may wish to ask

If you wish to learn more about what will happen, you can find a list of suggested questions called "[Having An Operation](#)" on the website of the Royal College of Surgeons of England. You may also wish to ask your surgeon for his/her personal results and experience with this procedure.

BAUS runs a national audit and collects data from all urologists undertaking this surgery. There are two reasons for this. First, surgeons are required by the Department of Health to look at how well the surgery is being done under their care and, second, to look at national trends for the procedure.

Some basic patient data (e.g. name, NHS number and date of birth) are entered and securely stored. This is required so that members of the clinical team providing your care can go back to the record and add follow-up data such as length of stay or post-operative complications. This helps your surgeon to understand the various outcomes of the procedure.

Although BAUS staff can download the surgical data for analysis, they **cannot** access any patient identifiable data. This information is used to generate reports on individual surgeons and units; these are available for the public to view in the [Surgical Outcomes Audit](#) section of the BAUS website.

Before you go home

We will tell you how the procedure went and you should:

- make sure you understand what has been done;
- ask the surgeon if everything went as planned;
- let the staff know if you have any discomfort;
- ask what you can (and cannot) do at home;
- make sure you know what happens next; and
- ask when you can return to normal activities.

We will give you advice about what to look out for when you get home. Your surgeon or nurse will also give you details of who to contact, and how to contact them, in the event of problems.

Smoking and surgery

Ideally, we would prefer you to stop smoking before any procedure. Smoking can worsen some urological conditions and makes complications more likely after surgery. For advice on stopping, you can:

- contact your GP;
- access your local [NHS Smoking Help Online](#); or
- ring the free NHS Smoking Helpline on **0800 169 0 169**.

Driving after surgery

It is your responsibility to make sure you are fit to drive after any surgical procedure. You only need to [contact the DVLA](#) if your ability to drive is

likely to be affected for more than three months. If it is, you should check with your insurance company before driving again.

What should I do with this information?

Thank you for taking the trouble to read this information. Please let your urologist (or specialist nurse) know if you would like to have a copy for your own records. If you wish, the medical or nursing staff can also arrange to file a copy in your hospital notes.

What sources have we used to prepare this leaflet?

This leaflet uses information from consensus panels and other evidence-based sources including:

- the [Department of Health \(England\)](#);
- the [Cochrane Collaboration](#); and
- the [National Institute for Health and Care Excellence \(NICE\)](#).

It also follows style guidelines from:

- the [Royal National Institute for Blind People \(RNIB\)](#);
- the [Information Standard](#);
- the [Patient Information Forum](#); and
- the [Plain English Campaign](#).

Disclaimer

We have made every effort to give accurate information but there may still be errors or omissions in this leaflet. BAUS cannot accept responsibility for any loss from action taken (or not taken) as a result of this information.

PLEASE NOTE

The staff at BAUS are not medically trained, and are unable to answer questions about the information provided in this leaflet. If you do have any questions, you should contact your urologist, specialist nurse or GP.