BULBAR 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.

http://rb.gy/5wtia

To view this leaflet online, scan the QR code (right) or type the short URL below it into your web browser:

KEY POINTS

- The bulbar urethra (circled below) is the commonest site for urethral narrowing
- Urethroplasty has a long-term success rate of more than 85% and is usually recommended in men with recurrent strictures
- Reconstruction involves either removing the stricture and re-joining the urethral ends or grafting the stricture, usually with buccal mucosa (the lining from the inside of the mouth)
- Bulbar urethroplasty is done in specialist reconstructive referral centres

What does this procedure involve?

We carry out this procedure for strictures of the bulbar urethra (between the scrotum and the anus). Often, these strictures do not have a clear underlying cause (referred to as **idiopathic**). Others may be due to sexually transmitted infections (STIs) or past use of instruments and/or catheters.

Because the bulbar urethra is relatively mobile, it is often possible to remove a narrowing less than 2cm long and re-join the ends over a catheter (**anastomotic urethroplasty**). Very short strictures can even be re-joined

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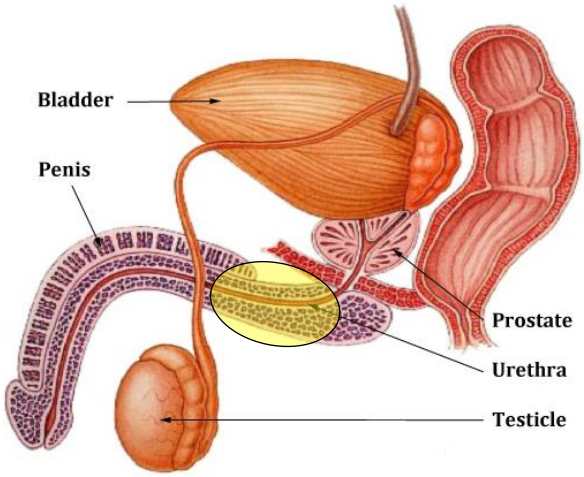
without removing any of the urethra (**non-transecting anastomotic urethroplasty**).



Longer, recurrent or complicated strictures need to be widened by cutting into the narrowed area and inserting a graft material (**augmentation urethroplasty**). For very long, scarred strictures, a combination of augmentation and re-joining (**augmented anastomotic urethroplasty**) may be needed.

Before agreeing to have the procedure, you may be asked to have a urethrogram. 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.

What are the alternatives?

- **Observation** - "doing nothing"
- **Optical urethrotomy** – a telescopic operation to cut through the narrowed area internally
- **Dilatation** – repeated stretching using plastic or metal dilators which you may need to continue yourself (intermittent self-dilatation)

Both optical urethrotomy and repeated dilatation carry a high risk of the stricture returning.

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 an 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.

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Details of the procedure

- we usually carry out the procedure under a general anaesthetic
- you will be given an injection of antibiotics before the procedure, after you have been checked carefully for any allergies
- we make an incision in your perineum (between the back of your scrotum and your anus)
- commonly, we open the urethra lengthwise along the narrowed portion; this is usually on the part of the urethra nearest to the erectile tissue
- in an anastomotic urethroplasty, we identify the ends of your urethra, remove any scar tissue and sew the healthy ends back together over a catheter
- if a graft is required (augmentation), we remove a strip of buccal mucosa (the lining inside your mouth) and sew it to your urethra
- your mouth wound will heal very quickly; some surgeons stitch the defect in your mouth whilst others leave it to heal on its own
- we close the skin with dissolvable stitches
- we may put in a temporary drain
- we put a catheter in your bladder which uisually needs to remain for one to three weeks
- the procedure takes, on average, 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
Urinary tract infection requiring treatment with antibiotics	 Between 1 in 2 & 1 in 10 patients
Swelling & bruising of the wound site	 Between 1 in 2 & 1 in 10 patients

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Discomfort or numbness in your mouth where the buccal mucosa graft was taken from inside the cheek		Between 1 in 2 & 1 in 10 patients
Dribbling after passing urine (post-micturition dribble)		Between 1 in 2 & 1 in 10 patients
Recurrent stricture formation requiring further surgery or other treatment		Between 1 in 10 & 1 in 50 patients
Erectile dysfunction which may require further treatment after the procedure		Between 1 in 10 & 1 in 50 patients (depends on age & other medical conditions)
Wound infection requiring treatment with antibiotics		Between 1 in 10 & 1 in 50 patients
Numbness in the back part of your scrotum		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 50 & 1 in 250 patients
Painful sexual intercourse with reduced force of ejaculation		Between 1 in 50 & 1 in 250 patients
Restricted jaw opening or persistent numbness in your lip after buccal mucosal graft harvesting		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)

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What is my risk of a hospital-acquired infection?

Your risk of getting an infection in hospital is between 4 & 6%; this includes getting *MRSA* or a *Clostridium difficile* bowel infection. Individual hospitals may have different rates, and the medical staff can tell you the risk for your hospital. You have a higher risk if you have had:

- long-term drainage tubes (e.g. catheters);
- 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, tablets or mouthwashes 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 (e.g. warfarin, aspirin, clopidogrel, rivaroxaban, 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.

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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 Smoke-Free National Helpline on **0300 123 1044**.

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 wish to have a copy for your own records. If you wish, they can also arrange for a copy to be kept 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

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- 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

Whilst we have made every effort to give accurate information, 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 have any questions, you should contact your Urologist, Specialist Nurse or GP in the first instance.

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