“Surgical Excision and Reconstruction for Bladder Cancer”
M. Maffezzini, Genova, Italy

United Nations World Regulation Prospect

Trends in Hospital Volume and Operative Mortality for High-Risk Surgery

Jonathan F. Field, M.D., Nicholas M. Osborne, M.D.

Median hospital volumes of four cancer resections (lung, stomach, pancreas, and bladder) and of repair of abdominal aortic aneurysm (AAA) rose substantially. Depending on the procedure, higher hospital volumes were attributable in an increasing number of cases to radiologic, as in decreasing rate of resection, or both. Hospital volumes rose slightly for aortic-valve replacement but fell for coronary-artery bypass grafting and carotid endarterectomy. Operative mortality declined for all eight procedures, ranging from a relative decline of 8% for carotid endarterectomy (3.3% mortality in 1999 and 1.2% in 2008) to 36% for AAA repair (4.4% in 1999 and 2.8% in 2008). Higher hospital volumes explained a large portion of the decline in mortality for pancreatic resection (62% of the decline), esophagectomy (77%), and nephrectomy (12%), but not for other procedures.

S.I.O.G.
Annual Meeting, Manchester  2012

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1 of 2 men with muscle-invasive bladder cancer undergoes Radical Cystectomy in the age range 54-65 ys, and from 65 – 74. The proportion drops substantially to 1 in 6 in men Aged 75 to 79 ys, and further to 1 in 10 in octogerians.

**Complications:**
- P.O.I. the most freq.!
- room for improvement?

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**# 4. INTERVENTIONS**

**Pre-Op:**
- Limited Mechanical Bowel Prep
- Dinner allowed before surgery
- c.v.c.
- epidural thoracic T10 - T11 cannula

**Intra-Op**
- Combined General Epidural Anaesthesia (No opioids)
- Controlled Hypotension 80 mmHg
- Epidural analgetics
- Timely Correction of Hypovolemia 500 ml blood loss
- Prevention of Hypoxia
- Prevention of Hypothermia
- Jejunostomy

**Post-Op:**
- NGT timely removal (6-8 H post-op)
- Early Passive/active Mobility
- Artificial Provision of Nutrients
- Soft Food per os allowed on POD 1
- Epidural analgetics (5 ml/h) first 50 post-op Hs.
Urinary Diversion and Morbidity After Radical Cystectomy for Bladder Cancer


BACKGROUND: The rate of continent urinary diversion after radical cystectomy for bladder cancer varies by patient and provider characteristics. Demonstration of equivalent complication rates independent of diversion type may decrease provider resistance to perform continent reconstructions. The authors sought to determine whether continent reconstructions confer increased complication rates after radical cystectomy. METHODS: From the Nationwide Inpatient Sample, we identified patients aged ≥30 years undergoing radical cystectomy from 2000 to 2010. RESULTS: We used principal diagnosis to define continent urinary diversion and compared total and continent urinary diversion complication rates. Rates for continent urinary diversion (1.5% points lower, 95% CI: 1.0% to 2.0% points lower) was lower than total urinary diversion (2.5% points lower, 95% CI: 2.0% to 3.0% points lower) and other surgical complications (1.0% lower, 95% CI: 0.5% to 1.5% points lower). CONCLUSIONS: Rates of continent urinary diversion after radical cystectomy were equivalent to those after total urinary diversion. These results may encourage broader consideration of continent urinary diversion without concern for increased complication rates. Cancer 2015;137:1136-1141. © 2015 American Cancer Society.

KEYWORDS: Bladder cancer, radical cystectomy, morbidity, urinary diversion.

Ileo-Colonic Pouch "Indiana"

Rowland RG, J Urol 137:1136-9, 1987

Pre-operative assessment of cancer in the elderly (PACE): A comprehensive assessment of underlying characteristics of elderly cancer patients prior to elective surgery


A Multimodal Perioperative Plan for Radical Cystectomy and Urinary Intestinal Diversion: Effects, Limits and Complications of Early Artificial Nutrition

Hamze Mohammadi, Guido Gerlicher, Fulse Carione, and D. Agustini

Table 2:  Data on patients who did and did not complete protocol

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Mean (SD)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haemoglobin</td>
<td>13.7 (3.2)</td>
<td>1.00</td>
</tr>
<tr>
<td>Platelet</td>
<td>14.0 (3.0)</td>
<td>1.00</td>
</tr>
<tr>
<td>Preoperative day 1</td>
<td>3.0 (1.2)</td>
<td>1.00</td>
</tr>
<tr>
<td>Preoperative day 5</td>
<td>3.0 (1.2)</td>
<td>1.00</td>
</tr>
</tbody>
</table>

* p = 0.000006.
**FREQUENCIES**

**URO-PROT Study**

- TESTOSTERONE
- LH
- FSH
- 17-ß-ESTRADIOL
- TSH
- FT3
- FT4
- CORTISOL
- SOMATOMEDINE
- PCR

Pre-Treatment

1°

3° {Post-Op}

5°

7°
<table>
<thead>
<tr>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Underuse of gold standard treatment, radical cystectomy and continent intestinal urinary reconstruction, due to m &amp; M</td>
</tr>
<tr>
<td>• Peri-operative <em>ad hoc</em> protocols can help in reducing m &amp; M risks</td>
</tr>
<tr>
<td>• Better assessment of baseline pre-operative parameters can guide individualized peri-operative support</td>
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