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EDITORIAL

by G. Carmignani

This issue contains a rather relevant number of videos, dealing with two important branches of our specialty: Reconstructive Urology and Endourology. Although they are very different indeed, both belong to Urology, that is one of the more complex and complete surgical specialties.

Another particular point of interest of this issue is that all the videos come from East Europe and this witnesses the willingness of these Countries to participate and to contribute to the progress of the European Urological Association, to which goes the merit, in my opinion, of having stimulated also Eastern Countries to feel themselves as an integrant part of the European Urology.

The comments to the videos have been written by outstanding experts such as Chris Chapple and Paul Van Cangh, to whom we all must be very grateful.

The next issue of the EUVJ will include some of the best and newest videos presented during the last EAU Congress in Brussels.

The full index of the coming issue and the trailers of the videos to be shown can be pre-viewed on-line to the following URL (web-address): http://www.unige.it/aduno/EUVJ/Euvj2.htm

Refinements in rectosigmoid vaginoplasty

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COMMENT

There are several techniques for creation of a neovagina in congenital absence of the vagina. Rectosigmoid segment presents the most natural substitute for vaginal tissue. The technique is effective and safe only in hands of surgeon who is very familiar with pre-, peri- and postoperative refinements; this significantly decreases the number of complications that usually occur in this type of vaginoplasty.

Preoperative evaluation involves assessment of the type of pelvis and perineum and characteristics of the rectosigmoid and its relationship to other pelvic organs and structures. This is crucial in patients who underwent previous surgery in that area.

Intraoperatively, before the rectosigmoid is finally chosen, one should assess the length of sigmoid and its mesentery to determine whether it reaches the pubic symphysis. If the lowest part of sigmoid can be pulled down to reach the pubic symphysis, a tension free rectosigmoid vagina can be anticipated. The isolated segment of rectosigmoid should be as short as possible of up to 10 cm. maximum in order to avoid excessive mucus production. Besides, it is adaptable to increase its length and girth, later on during sexual intercourse. The segment should be in the peristaltic configuration, not antiperistaltic. By reversing the segment neovaginal discharge can be lessened. In order to achieve better mobility of rectosigmoid, the rectal segment is divided from its mesentery, which remains vital due to good intramural vascularization. For the low colorectal anastomosis a stapling device is used as safest procedure. Reconstruction of the pelvic peritoneum has to be done to prevent bowel incarceration and strangulation. The difficult part of the operation is the creation of a perineal cavity for rectosigmoid vagina placement. Using a simultaneous approach through abdomen and perineum very precise dissection must be done in order to avoid injury of rectum, bladder and urethra. It is optimal to create a tunnel passable for three fingers. Various flaps, usually suburethral and perineal made from vaginal tag, are used for anastomosis to the rectosigmoid. In this way a circumferential anastomosis and vaginal prolapse are avoided. Pelvic perivaginal drains are used for the best drainage.
Postoperative dilation of neovagina is recommended to prevent introital stenosis during three months after surgery.

The rectosigmoid colon is the best choice for vaginoplasty, due to its size, location and ease of preserving the blood supply. Besides it has high sensitivity, especially its rectal part, produces natural lubrication without excess mucorhea and best resembles the vagina.

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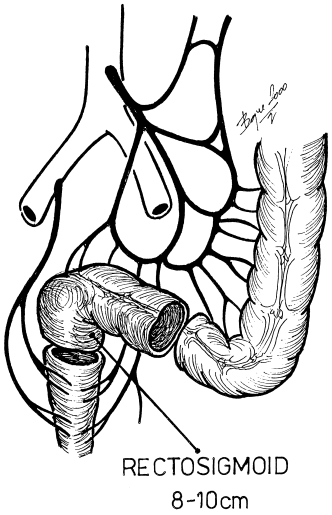

Fig. 1: *Rectosigmoid is harvested with blood supply originating on sigmoidal and superior haemorrhoidal vessels. Isolated segment should be as short as possible, usually up to 10 cm.*

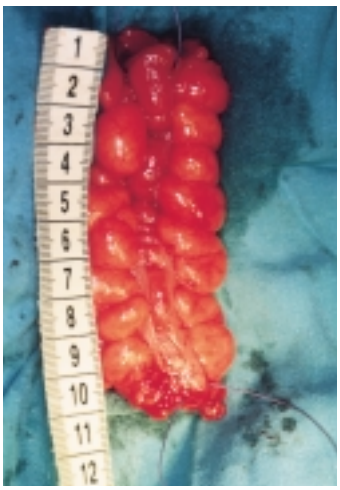

Fig. 2: *Rectosigmoid is harvested with length of 10 cm.*

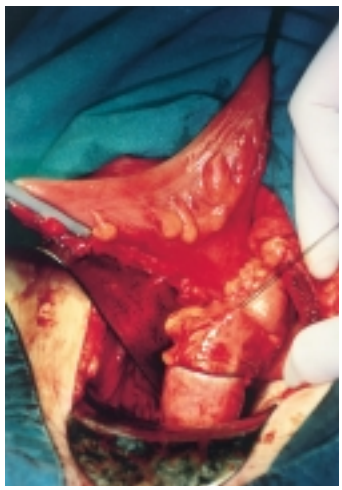

Fig. 3: *For restoring bowel continuity i.e. low colorectal anastomosis, stapling device is used as safest procedure.*

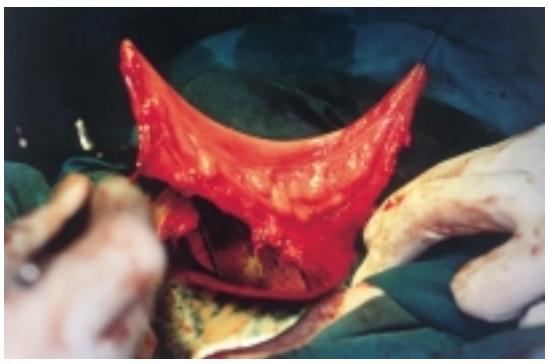

Fig. 4: *Isolated rectosigmoid segment is lengthened and straightened by partial division of its mesentery. It remains vital by blood supply from "marginal artery" and intramural vascularization.*

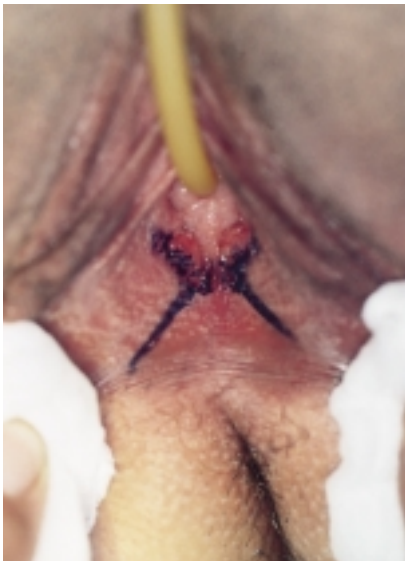

Fig. 5: *On vaginal tag two flaps, suburethral and perineal, are designed.*

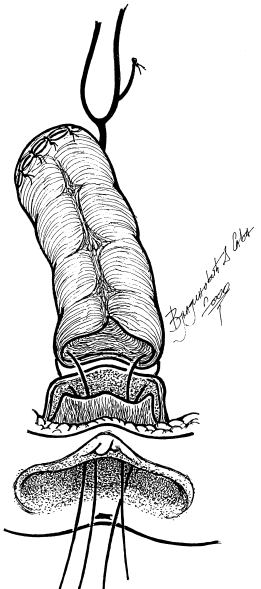

Fig. 6: *Anastomosis between rectosigmoid and suburethral and perineal flaps are made deeply in the perineum.*

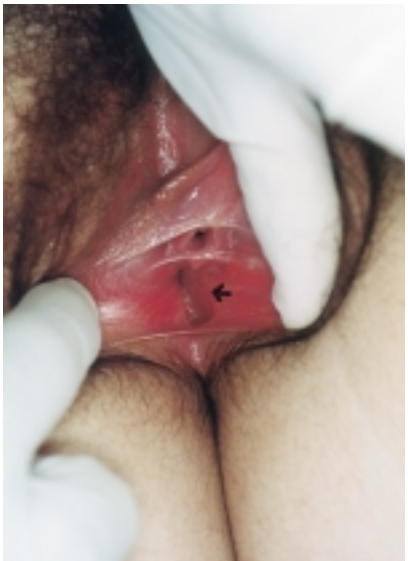

Fig. 7: *Two years after surgery. Normal appearance of vagina. Anastomotic line, which is not circular, lies deeply in the vagina. (arrow)*