



Chirurgie de l'obstruction sous-vésicale de l'homme et pathologie neurologique (syndromes parkinsoniens et AVC)

Xavier Gamé

Département d'Urologie

CHU Rangueil - Toulouse



Questions

- Origine des SBAU
- Prédire le résultat
- Place de la chirurgie/techniques
- Gestion des traitements de la maladie neurologique



Désobstruction prostatique chez patient parkinsonien = résultats aléatoires



Risques:

- Incontinence urinaire
- Echec et persistance dysurie - rétention

Merimsky J Urol Paris 1982

Statskin J Urol 1988



Aujourd'hui: Chirurgie prostatique chez patient parkinsonien: Meilleurs résultats

- Prostatectomie radicale:
 - 20 patients maladie de Parkinson.
 - 1 an après chirurgie
 - Patients secs: **65 %**
 - Pas de rétention
 - Incontinence de novo: 20 % (2 IUU, 1 mixte, 1 IUE)
- RTUP:
 - 23 patients maladie de Parkinson
 - 14 SAD
 - Mictions spontanées sans fuites ni résidu : 9
 - Rétention: 5 (AS: 1, SPC: 4)
 - 10 IUU
 - Patients secs: 5
 - Amélioration : 3
 - Echec: 2
 - Suivi de 3 ans : succès : **70 %**
 - Pas de facteurs retrouvés



Difficultés

- Diagnostic de la pathologie neurologique:
AMS vs maladie de Parkinson
- Dépister pathologie neurologique
- Pathologie neurologique connue:
Origine des TUBA : Obstruction vs pathologie neurologique



VENDREDI 22 JANVIER 2016

PARIS

DEBATS EN PELVI-PERINEOLOGIE
LES PATIENT(E)S À RISQUE

Diagnostic de la pathologie neurologique: MSA vs maladie de Parkinson

- AMS: Hypoactivité vésicale/dysfonction Sphinctérienne
 - Dysurie
 - Incontinence urinaire
 - Rétention d'urine
 - Parfois Urgenturie/Pollakiurie
 - Dyssynergie vésico-sphinctérienne

Second consensus statement on the diagnosis of multiple system atrophy

ABSTRACT

Background: A consensus conference on multiple system atrophy (MSA) in 1998 established criteria for diagnosis that have been accepted widely. Since then, clinical, laboratory, neuropathologic, and imaging studies have advanced the field, requiring a fresh evaluation of diagnostic criteria. We held a second consensus conference in 2007 and present the results here.

Methods: Experts in the clinical, neuropathologic, and imaging aspects of MSA were invited to participate in a 2-day consensus conference. Participants were divided into five groups, consisting of specialists in the parkinsonian, cerebellar, autonomic, neuropathologic, and imaging aspects of the disorder. Each group independently wrote diagnostic criteria for its area of expertise in advance of the meeting. These criteria were discussed and reconciled during the meeting using consensus methodology.

Results: The new criteria retain the diagnostic categories of MSA with predominant parkinsonism and MSA with predominant cerebellar ataxia to designate the predominant motor features and also retain the designations of definite, probable, and possible MSA. Definite MSA requires neuropathologic demonstration of CNS α -synuclein-positive glial cytoplasmic inclusions with neurodegenerative changes in striatonigral or olivopontocerebellar structures. Probable MSA requires a sporadic, progressive adult-onset disorder including rigorously defined autonomic failure and poorly levodopa-responsive parkinsonism or cerebellar ataxia. Possible MSA requires a sporadic, progressive adult-onset disease including parkinsonism or cerebellar ataxia and at least one feature suggesting autonomic dysfunction plus one other feature that may be a clinical or a neuroimaging abnormality.

Conclusions: These new criteria have simplified the previous criteria, have incorporated current knowledge, and are expected to enhance future assessments of the disease.

Neurology® 2008;71:670-676

GLOSSARY

¹²⁵I-CHEED = ¹²⁵I-chloroxyphedrine; AAN = American Academy of Neurology; AAS = American Autonomic Society; DSM-IV = Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition; DWI = diffusion-weighted imaging; ED = erectile dysfunction; PDG = ¹¹C-Pittsburgh neurodegeneration; FXTAS = fragile X-associated tremor/ataxia syndrome; MCP = middle cerebellar peduncle; MBI = ¹¹C-lmethylaspartate brain imaging; MR = magnetic resonance; MSA = multiple system atrophy; MSA-C = MSA with predominant cerebellar ataxia; MSA-P = MSA with predominant parkinsonism; OH = orthostatic hypotension; PD = Parkinson disease; SCA = sporadic cerebellar ataxia; SMC = Safety Monitoring Committee; RV = residual volume; UPDRS = Unified Parkinson's Disease Rating Scale.

Si AMS confirmée par neurologue: Attention à la chirurgie prostatique



Dépister la pathologie neurologique

- AMS: SBAU précèdent les symptômes moteurs



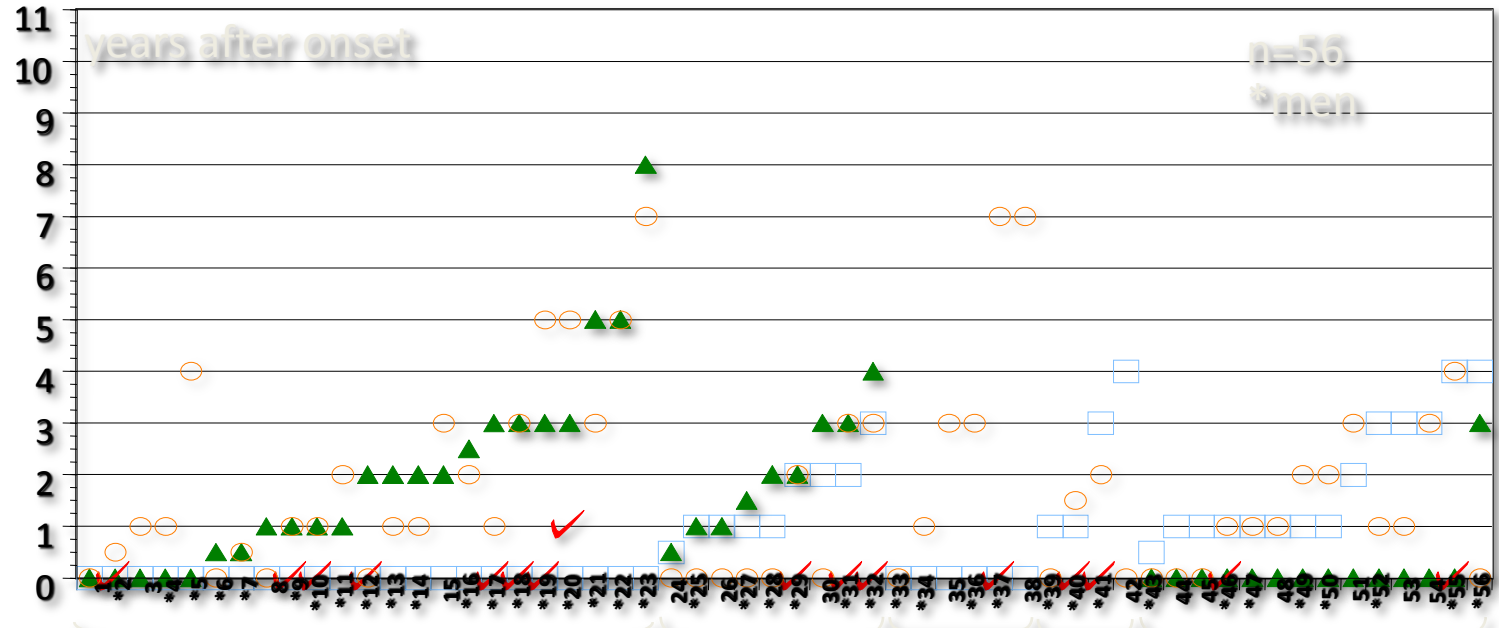


VENREDI 22 JANVIER 2016

Chronologie: PARIS

DEBATS EN PELVI-PERINEOLOGIE
LES PATIENT(E)S À RISQUE

DE puis SBAU puis HypoTA puis troubles de la marche



- uri>ortho/gait
- gait>uri>ortho
- uri>gait
- gait>uri
- ortho>uri/gait
- ✓ erectile dysfunction
- urinary symptom
- ▲ orthostatic symptom
- gait disturbance

Sakakibara



Dépister la pathologie neurologique

- AMS:
 - SBAU précèdent les symptômes moteurs
 - 1^{er} symptôme: Dysfonction érectile
- Signes d'alertes:
 - Dysfonction érectile sans cause déterminée voire précédant les TUBA
 - Hypotension orthostatique

=> Avant toute chirurgie : avis neurologique





AVC : BUD à la phase aiguë

AVC à la phase aiguë (72 heures)

N= 60 patients

28 patients (47%) = rétention urinaire → BUD = 75 % aréflexie

	AVC ischémique	AVC hémorragique	Cerebellar infarctus
BUD = aréflexie	4/40 = 10%	17/20 = 85%	6/6 = 100%

Acute cerebrovascular accident and lower urinary tract dysfunction: a prospective correlation of the site of brain injury with urodynamic findings. Burney T.L et al. J Urol. 1996



AVC: BUD à distance de l'accident aigu

Délai > 3 mois

	HYPERACTIVITE	HYPOACTIVITE	NORMAL	patients (n)
Perrigot et al 1977	61%	15%	24%	26
Kahn et al 1981	95%	0%	5%	20
Tsuchida et al 1983	89%	4%	8%	24
Pelissier et al 1985	72%	12%	16%	32
Linsenmeyer et al 1992	70%	12%	9%	33
Kim et al 2010	64%	36%	0%	69
Han et al 2010	60%	40%	0%	84
Yoo et al 2010	71%	29%	0%	62



Résultats BUD en fonction du type d'AVC

	Phase de remplissage	Phase de vidange
AVC hémorragique	73,3%	13,3%
AVC ischémique	63,6%	51,5%
	$P > 0,05$	$P < 0,02$

Étude retrospective; n= 48 patients avec TVS

Bladder storage and emptying disorder frequencies in hemorrhagic and ischemic stroke patients with bladder dysfunction. Ersoz M et al. Cerebrovascular dis. 2005



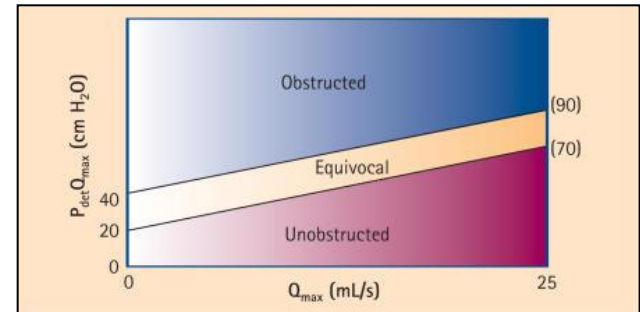
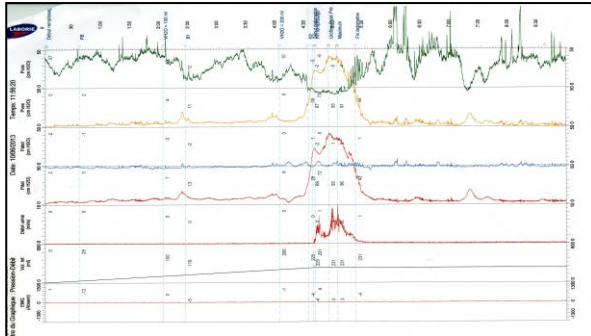
Éléments d'orientation

- SBAU pré-AVC ?
- Traitements antérieurs
- Suivi urologique



Pathologie neurologique connue: Origine des SBAU

- Moyen d'évaluation:
 - Etude pression/débit





Recommandations

Table 1 – Level of evidence and grade of recommendation for the assessment of non-neurogenic male lower urinary tract symptoms

Assessment tool	LE	GR
A medical history <i>must</i> always be taken from men with LUTS	4	A*
A validated symptom score questionnaire with QoL question(s) <i>should</i> be used for routine assessment of male LUTS in all patients and should be applied for re-evaluation of LUTS during treatment	3	B
Micturition FVCs or bladder diaries <i>should</i> be used to assess male LUTS with a prominent storage component or nocturia	3	B
FVCs should have a duration of at least 3 d	2b	B
Physical examination including DRE <i>should</i> be a routine part of the assessment of male LUTS	3	B
Urinalysis (by dipstick or urinary sediment) <i>must</i> be used in the assessment of male LUTS	3	A*
PSA <i>should</i> be measured only if a diagnosis of prostate cancer will change the management or if PSA can assist in decision-making for patients at risk of progression of BPE	1b	A
Renal function <i>must</i> be assessed if renal impairment is suspected based on history and clinical examination, if hydronephrosis is present, or when considering surgical treatment for male LUTS	3	A*
Measurement of PVR in male LUTS <i>should</i> be a routine part of the assessment	3	B
Uroflowmetry in the initial assessment of male LUTS <i>may</i> be performed and <i>should</i> be performed before any treatment	2b	B
Imaging of the upper urinary tract (with US) in men with LUTS <i>should</i> be performed in patients with a large PVR, haematuria, or a history of urolithiasis	3	B
When considering medical treatment for male LUTS, imaging of the prostate (either by TRUS or transabdominal US) <i>should</i> be performed if it assists choice of the appropriate drug	3	B
When considering surgical treatment, imaging of the prostate (either by TRUS or abdominal US) <i>should</i> be performed	3	B
Urethrocystoscopy <i>should</i> be performed in men with LUTS to exclude suspected bladder or urethral pathology and/or before minimally invasive/surgical therapies if the findings may change treatment	3	B
PFS <i>should</i> be performed only in individual patients for specific indications before surgery or when evaluation of the underlying pathophysiology of LUTS is warranted	3	B
PFS <i>should</i> be performed in men who have had previous unsuccessful (invasive) treatment for LUTS	3	B
When considering surgery, PFS <i>may</i> be used for patients who cannot void >150 ml	3	C
When considering surgery in men with bothersome predominantly voiding LUTS, PFS <i>may</i> be performed in men with PVR >300 ml	3	C
When considering surgery in men with bothersome predominantly voiding LUTS, PFS <i>may</i> be performed in men aged >80 yr	3	C
When considering surgery in men with bothersome predominantly voiding LUTS, PFS <i>should</i> be performed in men aged <50 yr	3	B

BPE = benign prostatic enlargement; FVC = frequency/volume chart; GR = grade of recommendation; LE = level of evidence; LUTS = lower urinary tract symptoms; PFS = pressure-flow study; PSA = prostate-specific antigen; PVR = post-void residual urine; QoL = quality of life; TRUS = transrectal US; US = ultrasound.

* Upgraded based on panel consensus.

EUROPEAN UROLOGY 67 (2013) 1088–1108

available at www.sciencedirect.com
journal homepage: www.eurourol.org

EAU
European Association of Urology

Platinum Priority – Guidelines
Editorial by Jean-Philippe Guille and Bernard Lohse on pp. 1110–1111 of this issue

EAU Guidelines on the Assessment of Non-neurogenic Male Lower Urinary Tract Symptoms including Benign Prostatic Obstruction

Christian Grotzke^a, Alexander Bachmann^b, Aurelien Descamps^c, Marcus J. Drake^d,
Stephan Madersbacher^e, Charalampos Mamoulakis^f, Matthias Oelke^g, Kari A.O. Tikkinen^h,
Stavros Grivas^{i,*}



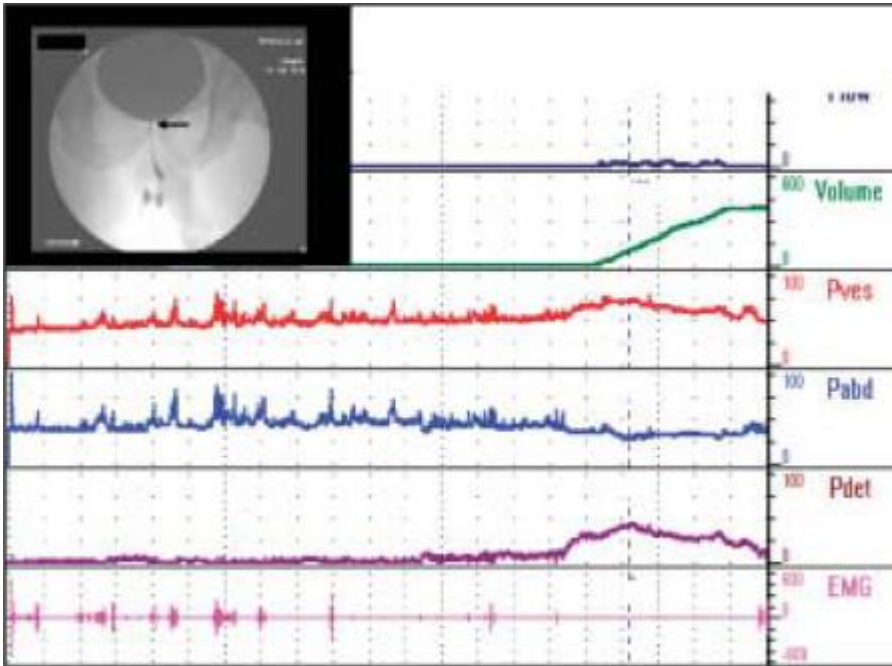
Limites de l'étude pression-débit

- Difficulté d'obtenir une miction
- Affirme l'obstruction mais:
 - Pas le siège de l'obstruction
 - Pas prédictif des résultats surtout si association de dysfonctionnements vésico-sphinctériens

=> Place de la vidéourodynamique ou de l'UCRM ?



Vidéo-urodynamique



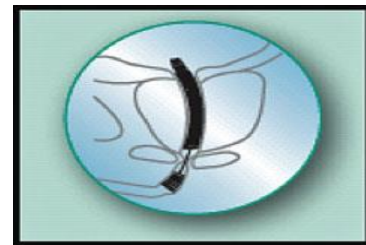
- Accessibilité ?



Test diagnostique et thérapeutique:

– Prothèse temporaire trans-prostatique

- Mime la levée chirurgicale de l'obstruction
- Prédiction des résultats
- Possibilité d'associer avec un traitement de l'HAV



Clinical Relevance of Urethral Stents (Urospiral 2™) Placement in Patients With Prostatic Obstacle and Concomitant High-Risk Surgical Status or Neurological Diseases: A Feasibility and Safety Study

Morgan Rouprêt, * Vincent Misraï, Aude de Fourmestraux, Florence Cour, François Richard, and
Emmanuel Chartier-Kastler

*ACADEMIC Department of Urology, Groupe Hospitalo-Universitaire EST, Pitié-Salpêtrière Hospital, Assistance
Publique-Hôpitaux de Paris (AP-HP), Faculté de Médecine Pierre et Marie Curie, University Paris VI, Paris, France*

- $n = 94$
- 12 patients maladie de Parkinson et 16 AVC
 - Durée moyen de prothèse: 78 ± 56 jours
 - IUU de novo: 3
 - Après résection: résultats identiques à ceux lors de la période avec prothèse

=> Si doute sur résultats et origine des troubles: intérêt
du test à la prothèse



VENDREDI 22 JANVIER 2016

PARIS DÉBATS EN PELVI-PÉRINEOLOGIE
LES PATIENT(E)S À RISQUE

Progrès en urologie (2013) 23, 296–308



Disponible en ligne sur
SciVerse ScienceDirect
www.sciencedirect.com

Elsevier Masson France
EM|consulte
www.em-consulte.com

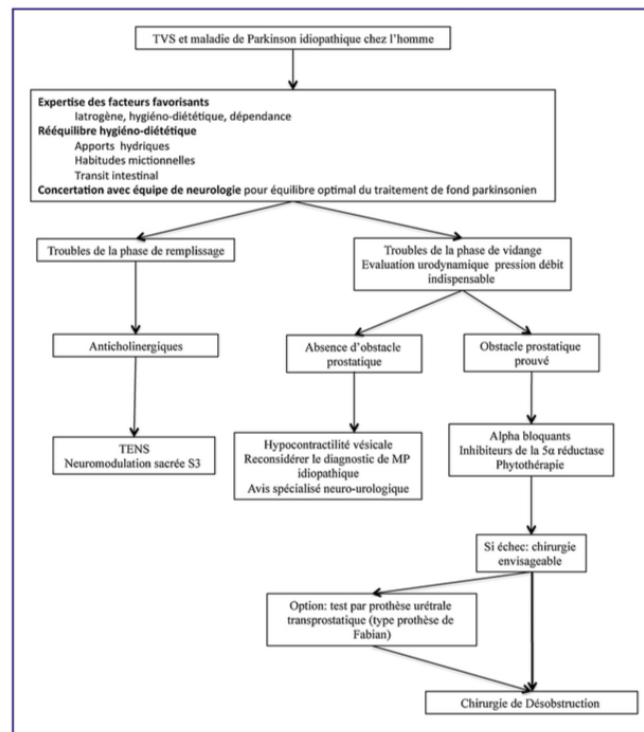


ARTICLE DE REVUE

Troubles vésicosphinctériens des syndromes parkinsoniens : une revue du comité de neuro-urologie de l'Association française d'urologie

Lower urinary tract dysfunctions in parkinsonian syndromes: A review by the neuro-urology committee of the French Association of Urology

V. Phé^{a,*}, R. Caremel^b, S. Bart^c, E. Castel-Lacanal^d,
M. de Sèze^e, F. Duchêne^f, A. Even^g, X. Gamé^h,
M. Loubatⁱ, M.C. Scheiber Nogueira^j, G. Karsenty^k,
le Comité de neuro-urologie de l'Association
française d'urologie





Chirurgie et traitement maladie de Parkinson

- Maintien du traitement (risque de syndrome de sevrage)
- Intérêt des galéniques orodispersibles ou injectables (traitement d'appoint des fluctuations sévères d'activités de la dopathérapie)
- Respect des horaires d'administration

Progres en urologie (2013) 23, 309–316



MISE AU POINT

Le parcours de l'opéré en neuro-urologie : de la programmation opératoire à la convalescence. L'avis d'expert du Comité de neuro-urologie de l'AFU

Expert opinion on surgical care pathway management of neurologic patients from neuro-urology committee of the French national association of urology (AFU)

R. Caremel^{a,*}, V. Phé^b, S. Bart^c, É. Castel-Lacanal^d,
M. De Sèze^e, F. Duchene^f, M. Bertrand-Loubat^{g,h},
M. Mazerollesⁱ, M.-C. Scheiber-Nogueira^j,
G. Karsenty^{k,h}, X. Game^l



Chirurgie et traitements AVC

- Traitements anticoagulants
- Traitements symptomatiques (antispastiques et antiépileptiques)
 - A poursuivre
 - A majorer parfois
 - A adapter à la clinique en postopératoire

Progrès en urologie (2013) 23, 309–316



Disponible en ligne sur
SciVerse ScienceDirect
www.sciencedirect.com

Elsevier Masson France
EM|consulte
www.em-consulte.com

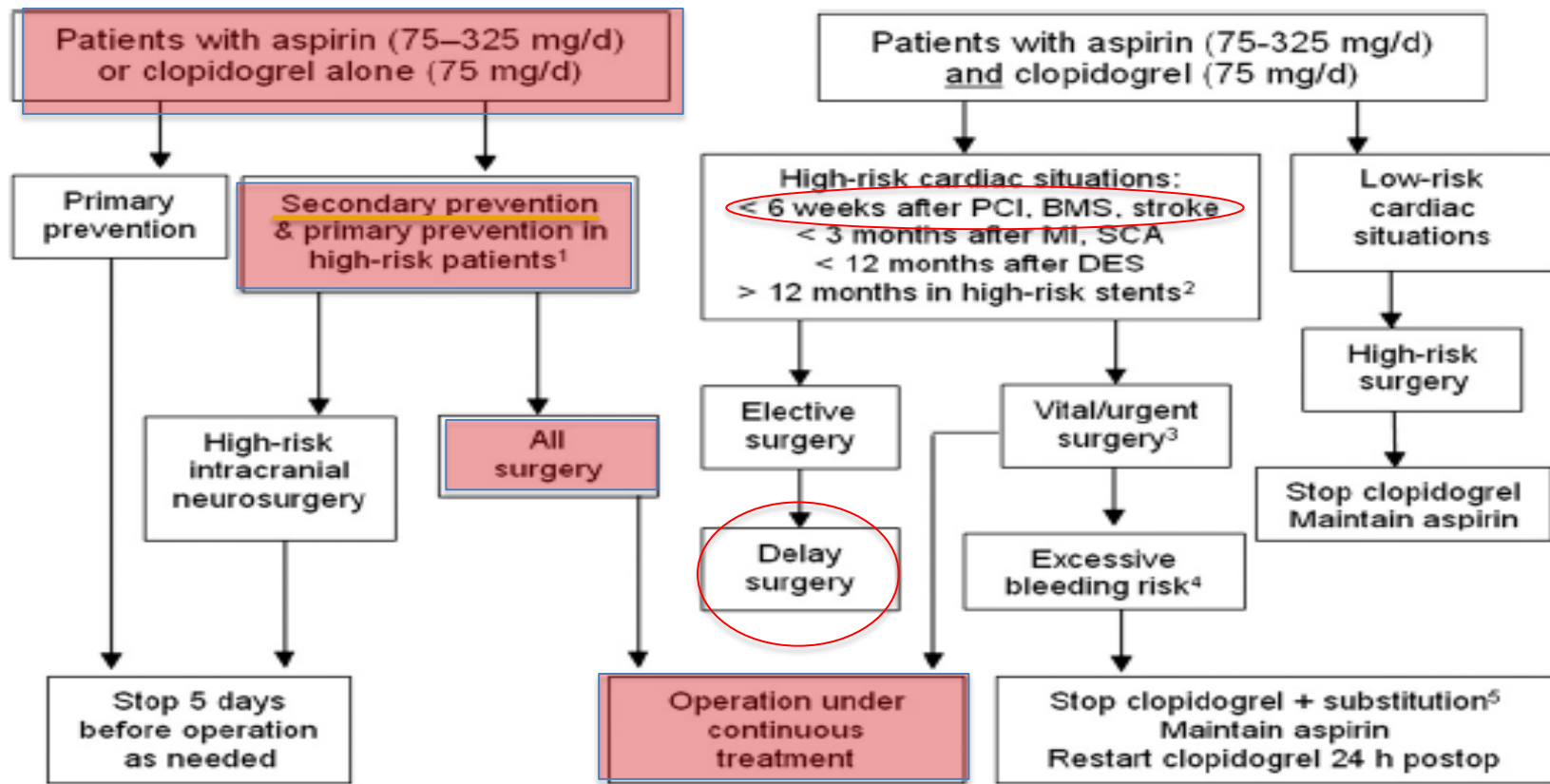


MISE AU POINT

Le parcours de l'opéré en neuro-urologie : de la programmation opératoire à la convalescence. L'avis d'expert du Comité de neuro-urologie de l'AFU

Expert opinion on surgical care pathway management of neurologic patients from neuro-urology committee of the French national association of urology (AFU)

R. Caremel^{a,*}, V. Phé^b, S. Bart^c, É. Castel-Lacanal^d,
M. De Sèze^e, F. Duchene^f, M. Bertrand-Loubat^{g,h},
M. Mazerollesⁱ, M.-C. Scheiber-Nogueira^j,
G. Karsenty^{k,l}, X. Gaméⁱ



High risk = diabétiques ou fdr cumulés



AAP et Risque hémorragique en chirurgie (non spécifique de l'urologie)

Table 1

Guidelines in management of patients on anti-platelet agents requiring elective surgery according to risk level

Patient risk level	Surgical hemorrhagic risk	Suggestion
I) Low CVD risk: • 6 months after MI, PCI, BMS, CABG, stroke • 12 months if with complications	A) Low (superficial such as circumcision)	Proceed with elective surgery on ASA
	B) Intermediate (such as transurethral cases)	Proceed with elective surgery on ASA
	C) High (possible bleeding in a closed space such as SWL)	Proceed with elective surgery on statin; Withdraw ASA (maximum 7 days)

Alsaikhan et Andonian Can J urol 2011

Di Minno et al. Intern Emerg Med. 2009

Remarque:

La phase « chronique post AVC » vis à vis du risque chirurgical commencerait à 6 mois post événement (reco. empirique)



Techniques opératoires sous anticoagulants

- Vaporisation bipolaire
- Lasers :
 - Photovaporisation (Greenlight)
 - Enucléation (HoLEP)



REVIEW



Bladder outlet procedures in the setting of anticoagulation therapy

Tracy Marien and Ojas Shah



Sécurité Laser 120 W et anticoagulation

D.Chung, Chicago, J of Urol, 2011

162 patients à haut risque de saignement (anticoag, 1 ou 2 antiag) entre 2002 et 2008.

Scores moyens : ASA : 3 ; Charlson : 5

	AVK	Aspirine	Clopidrogel	Aspirine+ Clopidrogel
162 patients	31 (19%)	101 (62%)	19 (12%)	11 (7%)
transfusion	0	0	0	0
IDM : 1	Remplissage++			
Hématurie+++	2	2	1	1

0 DCD ; 1 ré-intervention pour hémorragie.



Amélioration de la sécurité de l'hémostase

- Etude prospective Horasanli, Urology 2008 :
Transfusion 8% RTUP Vs 0% Laser 80 W
- Thangasamy , méta-analyse de 2002 avec Laser 80 et 120W
Taux de transfusion : 1 cas sur 366 PVP versus 25 cas sur 350 RTUP



Conclusion

- Chirurgie de l'obstruction : oui ... mais:
 - Attention à l'AMS
 - Evaluation urodynamique préopératoire systématique
 - Test à l'endoprothèse ?
 - Risque d'IUU
 - Attendre au moins 3 à 6 mois après un AVC
 - Laser ou vaporisation bipolaire si anticoagulants