



Response to editorial comment “A retrosigmoid ileal conduit might prevent ureteroileal anastomotic stricture after ileal conduit diversion”

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We thank the authors for their interest in our recent article describing the surgical technique and early functional results of a retrosigmoid ileal conduit diversion after radical cystectomy (RC) (1). In a single-centre single-surgeon comparative study with a short-term follow-up, we observed a significantly reduced rate of ureteroileal anastomotic stricture (UAS) and no increase in intra- or postoperative complications with the retrosigmoid versus traditional Wallace ileal conduit. In details, no cases of UAS were detected in 30 patients who had received a retrosigmoid ileal conduit with a direct end-to-side ureteroileal anastomosis after a mean follow-up time of 10.8 months.

Following these encouraging results, the retrosigmoid approach has been applied to all patients receiving RC with ileal conduit at our institutions. Between April 2017, i.e., the termination date of the above comparative study, and September 2018 a further 33 patients treated with RC received a retrosigmoid ileal conduit, thus resulting in a prospective cohort of 63 patients. The latter patients were treated at two academic centres by one of three surgeons with varying experience. After a mean follow-up of 18.2 months there were still no cases of UAS. No intraoperative complications were observed. Ninety-day overall complications, classified according to the Dindo

modification of the Clavien system (2), were recorded in 28/63 (44%) patients, and major complications in 12/63 (19%) patients. Most common major complications were represented by wound infection/dehiscence and lymphocele. No single case of ureteroileal anastomotic leakage or any urinary fistula was observed.

We would like to address the authors' concern on the applicability of this technique to obese patients by noting that 16/63 (25%) patients in our series had a body mass index exceeding 30 kg/m². The retrosigmoid approach was feasible in all of them with no increase in operating room time or morbidity. The length of the ileal segment that has to be taken to build the conduit can easily be adapted to the size and thickness of the mesentery and sigmoid.

We would also like to mention a potential condition where the retrosigmoid ileal conduit would be useful. If a patient has a high risk of experiencing unilateral nodal progression (i.e., bulky regional nodal disease, incomplete regional lymph node dissection), then a traditional conduit diversion with both ureters on the same side of the pelvis/retroperitoneum would predispose him to bilateral ureteric obstruction in case of nodal compression/infiltration occurring in the ipsilateral side. On the contrary, if the ureters are kept in their naïve location using a retrosigmoid

approach for the ileal conduit, one renal unit remains safe in case of unilateral nodal progression.

The retrosigmoid approach has now become the standard option for patients receiving an ileal conduit in our clinical practice. We will continue to follow-up our patients in order to assess the long-term functional results, although it is known that the risk of UAS is very low after 18 months after surgery, as already acknowledged by the authors. Our data await external validation from large cohorts of other centres. We also look forward to studies where a robot-assisted approach for this technique is attempted.

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Footnote

Conflicts of Interest: The authors have no conflicts of interest to declare.

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