

Dr. Richard Santucci: developments in trauma and reconstructive urology

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Dr. Richard Santucci (*Figure 1*), Director of the Center for Urologic Reconstruction and the Specialist-in-Chief for Urology at the 9-Hospital Detroit Medical Center, is an expert in trauma and reconstructive urology. As a physician researcher, Dr. Santucci has authored over a hundred journal articles, abstracts and book chapters. In addition, he has presented at national and international conferences and trained other urologists in complex urethral reconstruction procedures. Dr. Santucci is a member of the American Urological Association and a Fellow of the American College of Surgeons.

ACS CHICAGO 2015, Clinical Congress of American College of Surgeons was held from Oct. 04 to Oct. 08, which offered cutting-edge educational opportunities to address the skills and professional problems for physicians. We were honored to invite Dr. Santucci for an interview to review the developments in trauma and reconstructive urology during the congress after his speech on “Genitourinary Trauma”.

TAU: *What is the most challenging issue in the field of reconstructive urology?*

Dr. Santucci: In urologic reconstruction, we must functionally reconstruct important parts of the body (say those responsible for storage or transport of urine), but our technology and skillset greatly lags behind what we need to do that job perfectly. Even as much as we have achieved in the field, I’d like to think of these as the “Dark Ages” of reconstructive urology. In the future I’d like to think we will be capable of so much more. For starters, what we really need is “off the shelf” material, which can be used to reconstruct the urethra, bladder and ureter. Right now, we are using natural tissues from the body and donor sites morbidity limits how much of that tissue you have. The biggest challenge within this field is that we are waiting a breakthrough in biotechnology to give us the material we need to really excel!

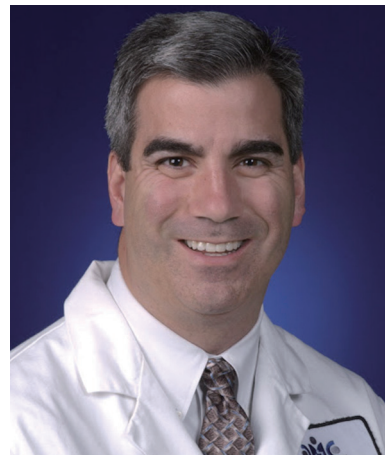


Figure 1 Dr. Richard Santucci.

TAU: *What can you say about progress in reconstructive urology over the past few years?*

Dr. Santucci: We have recently learnt to be even more scientific when researching the issues in our field, and to better use multicenter or highly designed trials to answer big questions. This will help our whole field advance faster and better. It’s only been recently that we codified the treatment for long difficult urethral strictures, for example. I and others use the dorsal buccal onlay urethroplasty described by Kulkarni in these cases, so that’s a “win”. But these difficult cases still have a 20% failure rate, are quite technically demanding, and often require 3 or 4 sites of oral mucosal graft harvest: so you’ll have to classify that as a “small win”. We still have a lot of work to do.

In renal trauma, I think we have gotten much smarter about just who needs surgery and who does not. Twenty years ago, when we had mastered difficult kidney operations like partial nephrectomy, we operated on most patients with renal injury because we were sure it was the best thing. Now, starting with the work of my mentor Dr. McAninch, and using datasets from our medical center and later all over the world, we realize

that most of these injuries do not require surgery. Even more recently, we've seen that those renal injuries which are bleeding significantly might be best treated by angioembolization. We've come a long way and saved a lot of traumatized kidneys...

TAU: Any insights of future development in the field of reconstructive urology?

Dr. Santucci: As I've said, I think in the reconstruction world, the next big bright prospect is "off the shelf" reconstruction material. However, that surely isn't the only story. One of the most exciting areas for improvement in reconstruction is use of robotic surgery. We are now doing robotic operation that previously were only done open, as a matter of course. Ureteropelvic junction (UPJ) obstruction is most often repaired robotically, but now we and others pushing ahead to do robotic buccal ureteroplasty or even robotic ileal ureters, which is a highly technical operation. I think there is no question that some cases of rectovaginal, uretero-vaginal or vesico-rectal fistula should be repaired robotically and that the patient will be better off for it.

TAU: Why do you love surgery?

Dr. Santucci: I really do love surgery. I became an

urologist because our surgery "works". As urologists, we have a high success rate of many of our cancer surgeries and we can often help patients through our reconstruction surgery techniques. In my sub specialty field, the cost-benefit ratio of what we do to our patients is often very favorable. So it is true: I really love surgery, and I love urology, and reconstructive urology perhaps most of all, because they work to make our patients better!

Acknowledgements

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Footnote

Conflicts of Interest: The author has no conflicts of interest to declare.

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