Biopsie prostatique transrectale au chu yo: analyse de l’acceptabilité, de la tolérance et des facteurs de risque de complications

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Objectif: étudier l’acceptabilité, la tolérance et les facteurs de risque de complication des biopsies transrectales digito-guidées de la prostate au CHUYO de Ouagadougou

Patients et Méthodes: Il s’estagi d’une étude transversale à caractère analytique. Cette étude s’est déroulée du 01er Mai au 31 Novembre 2012. Tous les patients ayant subi une biopsie prostatique pendant la durée d’étude ont été inclus. Les paramètres liés aux caractéristiques sociodémographiques des patients ont été recueillis, un questionnaire semi structuré recueillant des informations sur l’acceptabilité, la tolérance du geste ainsi que la recherche des facteurs de risque de complications a été administré à chaque patient. Les données étudiées ont été évaluées en termes de fréquence, de moyenne et d’écart-type.

Résultats: Soixante-sept patients avec un âge moyen de 71,7 ans ont été admis dans l’étude. Soixante-sept virgule un pour cent des patients n’ont pas éprouvé de gêne au cours de la biopsie. 63 patients soit 94% se disaient être prêts pour une reprise du geste. 64,2% connaissaient le nom de l’acte. 26,9% avaient reçu une information sur la technique de la biopsie et 14,9% l’information sur le geste. 64,2% connaissaient le nom de l’acte. 26,9% avaient reçu une information sur la technique de la biopsie et 14,9% l’information sur le geste. 64,2% connaissaient le nom de l’acte. 26,9% avaient reçu une information sur la technique de la biopsie et 14,9% l’information sur le geste.

Conclusion: la biopsie transrectale était bien tolérée dans notre pratique courante. Cette étude a fourni une occasion d’amorcer une véritable communication entre médecin et malade.

Determinants of peri-operative blood transfusion in a contemporary series of open prostatectomy for benign prostate hyperplasia

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Introduction: An increased blood transfusion rate in open prostatectomy for benign prostate hypertrophy (BPH) is well noted. In developing countries where open prostatectomy is currently mostly practiced, assess to blood for blood transfusion is limited as there is less voluntary blood donation. These surgeries are sometimes unduly delayed on account of lack of acceptable replacement donors. Blood transfusion also carries risks of transfusion reactions and disease dissemination as well as a substantial economic cost. Being able to determine the factors that predispose a patient to receiving blood transfusion peri-operatively at open prostatectomy will enable a more rational blood product management for the procedure.

Objectives: To determine the factors predisposing to peri-operative blood transfusion in open prostatectomy for BPH that will subsequently form a basis towards blood product management for the procedure.

Methods: This was a prospective study of consecutive patients who underwent open prostatectomy for benign prostate hyperplasia from January 2010 to June 2012 at the Urology Unit of the Korle Bu Teaching Hospital Accra, Ghana.

The patients scheduled for open prostatectomy for BPH underwent anaesthetic evaluation with the determination of the hemoglobin level and the presence of co-morbidities. The patients who were found fit and consented to undergo either transvesical open prostatectomy or retropubic open prostatectomy and the study were considered. The additional data collected and imputed into the proforma included the case type – elective or emergency, the indication for the surgery, the anaesthetic method used, the status of the operating surgeon – consultant or resident, the duration of surgery, prostate weight, and the estimated blood loss.

Also documented was the units of blood transfused peri-operatively. The data was analyzed using the statistical package for the social sciences (SPSS) version 16.

Results: One hundred and forty-nine patients were studied. The mean age of the patients was 69.9 ± 9.0 years (range 48–92yrs). One hundred and thirty (87.2%) of the cases were elective cases while 19 (12.8%) were emergen-
cases. With regards to the indication for the prostatectomy, 66.4% was as a result of refractory retention of urine, 22.1% haematuria due to BPH, 6.7% severe lower urinary tract symptoms, 3.4% BPH with associated bladder calculi, 0.7% BPH with obstructive uropathy and 0.7% refractory reten-
tion with stuck urethral catheter. The mean pre-operative haemoglobin level was 12.0 ± 2.4 g/dl (range 3.1–16.4 g/dl). With regards to the presence of co-morbidities, 83 (55.7%) of the patients had no co-morbidities while 66 (44.3%) had associated co-morbidities such as hypertension and diabetes mellitus.

Seventy (47.0%) of the surgeries were performed by residents while 79 (53.0%) of the surgeries were by consultants. Open transvesical prostatectomy was the operative method used in 133 (89.3%) with retropubic prostatectomy in 16 (10.7%). The mean operative time was 102.3 ± 31.6 min (range 35.0–230.0 min) with 123 (82.6%) of the surgeries done under spinal anesthesia, 20 (13.4%) under general anaesthesia and 6 (4.0%) with epidural anaesthesia. The mean operative prostate weight was 112.5 ± 91.1 g (range 15–550 g) and the estimated blood loss ranged from 100 to 2400 ml.

The peri-operative blood transfusion rate was 21.5% (32/149), a total of 68 units of blood were transfused. The transfusion rate as seen at various haemoglobin levels were, 84.6% in patients with Hb level ≤ 8.0 g/dl, 75% (Hb 8.1–9.0), 60% (Hb 9.1–10.0), 25% (Hb 10.1–11.0), 10% (Hb 11.1–12.0), 15.4% (12.1–13.0), 2.8% (Hb 13.1–14.0) and no transfusion in patients with Hb > 14.0 g/dl.

There was a significantly higher blood transfusion rate in emergencies cases compared to elective cases (X² = 42.651, p < 0.001) and in patients without co-morbidities compared to patients with co-morbidities (X² = 4.596, p < 0.05). Compared to spinal anaesthesia, patients that underwent the procedure under general anaesthesia had a higher blood transfusion rate (X² = 7.585, p < 0.05).
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Advanced prostate cancer

Testicular atrophy in patients with prostate cancer (CaP) has been associated with poor outcome. We have previously reported that 65% of our newly diagnosed CaP patients treated with bilateral orchidectomy had testicular atrophy. This is a pilot retrospective study evaluating the relationship between histologic grade and severity of testicular atrophy in these patients.

Methods: Data was collated from records of patients who had therapeutic bilateral orchidectomy for prostate cancer between 2002 and 2012. The Histology was reported by a Consultant Pathologist. Testicular atrophy was staged and managed by approved protocols. Organ confined PC by radical prostatectomy (RP), brachytherapy (BRCHY), external beam radiotherapy (EBRT), Hormonal/Chemotherapy, or surveillance if life expectancy less than 15 years. T3-4M0 treated by hormonal/chemotherapy ± Total androgen blockade (TAB), BRCHY/EBRT. Metastatic T1-4-M1 is treated by hormonal/chemotherapy ± TAB. Significant LUTO is treated by alpha blockers, TUIP/TURP.

Results: There were 669 cases median age 70 years, median GS 7, organ confined PC 415 (62%), T3-4 M0 167 (25%), METASTATIC CASES 87 (13%). The report on 669 cases were followed for 1–7 years is as follows.

A. Organ Confined T1-2 No Mo PC – n=415 presentation is asymptomatic. Symptomatic cases 1–20% treatment regimes

i) Radical Prostatectomy – n=92. Open retropubic/prior median PSA 16.1 ng/ml, post PSA 0.23 ng/ml. RP specimen BPH = 3, organ confined 76, positive margins 13. Complications rate (COMP) 3–22%.

ii) Brachytherapy – n=70.145. median prior PSA 14.6 ng/ml, post PSA 0.59 ng/ml. COMP 3–10%.

iii) EBRT no=n=155. 70/74GY. median prior PSA 14.6 ng/ml, post PSA 0.54 ng/ml. COMP 2–6%.

iv) Hormonal Chemotherapy + TAB – n=98 prior median PSA 48.5 ng/ml, post PSA 0.6 ng/ml. METHODS LHRH analogue /Chemotherapy 41%, stilboesterol 29%, BTO 30%. COMP 4–30%.

v) Surveillance GS 6.prior PSA < 8 ng/ml. Significant LUTO is treated by alpha blockers, TUIP/TURP. Presentation symptomatic 60%.

All had neoadjuvant hormonal/chemotherapy + TAB, LHRH 52%, stilboesterol 12%, BTO36% then

i) Bicalutamide – T3N3, prior PSA 14.6 ng/ml, post PSA 0.11 ng/ml.

ii) EBRT no=64. Prior PSA T3 (34%) 32.4 ng/ml, T4 (2%) 64.6 ng/ml. Post PSA T3 0.6 ng/ml, T4 0.4 ng/ml. COMP = 2–70%.

iii) Hormonal chemotherapyn =103 (T3 24%, T4 38%), LHRH 28% stilboesterol 4%, BTO 30%, COMP 4–35%, Hospitalmortality 26.3%.

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Relationship between Gleason’s grade and Testicular atrophy in patients with advanced prostate cancer

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Introduction: Testicular atrophy in patients with prostate cancer (CaP) has been associated with poor outcome. We have previously reported that 65% of our newly diagnosed CaP patients treated with bilateral orchidectomy had testicular atrophy. This is a pilot retrospective study evaluating the relationship between histologic grade and severity of testicular atrophy in these patients.

Methods: Data was collated from records of patients who had therapeutic bilateral orchidectomy for prostate cancer between 2002 and 2012. The Histology was reported by a Consultant Pathologist. Testicular atrophy was graded as none (normal), mild, moderate or severe based on the degree of testicular tubular sclerosis found at histology. CaP specimens were graded using the Gleason scoring systems. Analysis was done using SPSS version 18.

Results: The histology of 164 prostate biopsies and 113 orchidectomy specimens from prostate cancer patients were analyzed. The age range was 36-91 years; mean age was 69.23 years (SD 9.446 years). The Gleason’s score ranged 4–10, mean 6.95 (SD 1.44). 64 patients (39%) had GS of 4–6, 87 (53%) had GS of 7–8 and 13 (8%) had GS ≥9. 21 (18.6%) had normal testis, 39 (34.5%) had mild, 16 (14.2%) had moderate and 37 (32.7%) had severe testicular atrophy. There was no statistically significant difference in GS among the four groups; = 1.555; Sig. 0.221.

Conclusion: Most patients in our environment with advanced prostate cancer have testicular atrophy, the degree of which is unrelated to histology grade of the tumour.

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Prostate cancer (PC)-management of 669 cases in Ghana West Africa

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Objectives: To study clinical incidence of histologically proven PC, TNM stage and management outcomes.


Diagnosis by history, Hogh PSA, physical and abnormal DRE and histologically confirmed by biopsy. With gleason scores (GS) and TNM staged and managed by approved protocols. Organ confined PC by radical prostatectomy (RP), brachytherapy (BRCHY), external beam radiotherapy (EBRT), Hormonal/Chemotherapy, or surveillance if life expectancy less than 15 years. T3-4M0 treated by hormonal/chemotherapy ± Total androgen blockade (TAB), BRCHY/EBRT. Metastatic T1-4-M1 is treated by hormonal/chemotherapy ± TAB. Significant LUTO is treated by alpha blockers, TUIP/TURP.

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