

TRAINING

IN

RECONSTRUCTIVE

UROLOGY

Reconstructive Urology

Reconstructive urology is different from mainstream urology because it is mainly open surgery and depends on a greater than usual familiarity with general surgical and plastic surgical techniques. There is a considerable overlap with female urology in the area of complex incontinence and fistula. There is some overlap with paediatric and adolescent urology in the reconstruction of congenital malformations, and in neuropathic bladder dysfunction, and there is some overlap with urological oncology in the area of bladder replacement. There is some overlap too with andrology in the area of penile reconstruction in congenital and traumatic conditions.

Trainees in reconstructive urology should have completed their core training and should have a particular familiarity with urodynamics as well as endoscopic evaluation of the lower urinary tract.

Training in reconstructive urology as a special interest will take a minimum of one year. Training to sub-specialist level will take a minimum of two years.

As part of their training, trainees will be expected to read widely, attend any relevant national or international meetings and to involve themselves in the audit and research activity of the training unit. The principle areas of surgical activity in reconstructive urology are:

- 1 Dealing with ureteric defects from whatever cause: usually by psoas hitch, Boari flap or transureteroureterostomy, but occasionally by ureteroureterostomy or ureteric replacement with ileum.
- 2 Bladder augmentation and substitution including continent urinary diversion for neurological or malignant disease.
- 3 Urethral reconstruction by anastomotic and substitution urethroplasty (single stage or staged) for traumatic or other acquired stricture disease and hypospadias.
- 4 In addition trainees need to be familiar with the principles of vaginoplasty, anorectal reconstruction, scrotal and penile reconstruction and bowel surgery.
- 5 Complex sphincter weakness incontinence, in neuropathy or following previous surgery, in patients of either sex.

At the end of “special interest” training in reconstructive urology a urological trainee should be able to:

- 1 Be competent in the assessment and investigation of reconstructive problems and be able to formulate a plan of management.
- 2 Deal with a distal ureteric stricture or fistula by psoas hitch or Boari flap.
- 3 Perform an augmentation cystoplasty for functional bladder disorders such as in neuropathy.
- 4 Perform a substitution cystoplasty or continent diversion after a cystectomy for bladder cancer.
- 5 Implant a bulbar urethral artificial sphincter for post-prostatectomy incontinence.
- 6 Perform a straightforward patch urethroplasty using a buccal mucosal or other free graft.
- 7 Perform a straightforward anastomotic urethroplasty in the bulbar urethra.
- 8 Know when not to do anything but refer the patient on to someone more experienced. And should have a documented portfolio of experience to substantiate that claim together with his trainer’s affidavit that he is competent in each and every one of those areas.

A training unit in reconstructive urology should be able to provide a reasonable throughput of patients with stricture disease; requiring cystoplasty for neuropathic bladder and other

functional disorders; requiring cystoplasty for bladder cancer with hypospadias, exstrophy and other congenital anomalies, with post-traumatic problems of the urinary tract; and with the urological complications of gynaecological and other surgery. The unit should be generally acknowledged as a tertiary referral unit for reconstructive urology and the lead trainer should likewise be generally acknowledged as a sub-specialist in reconstructive urology.

Sub-specialty training would require additional experience of, and documented competence in, anastomotic urethroplasty for pelvic fracture urethral distraction defects; the correction of congenital anomalies; and in the management of other complex “inter-disciplinary” problems.

Most importantly at the end of his training in reconstructive urology the trainee urologist should feel competent to be able to deal with the conditions referred to above.

Trainee Year of Training

	Completed by Trainee						Completed by Trainer							
	On appointment			At Completion			Competence level at 6 months				Competence level at 12 months			
	Seen	Assisted	Solo	Seen	Assisted	Solo	1	2	3	4	1	2	3	4
Reconstructive urology														
Ureteric reconstruction														
Ureteric replacement														
Transuretero-ureterostomy														
Psoas hitch/ Boari flap														
Closure of vesico-vaginal fistula														
Augmentation cystoplasty														
Substitution cystoplasty														
Continent diversion														
Anastomotic urethroplasty														
Surgery for hypospadias														
Patch urethroplasty														

Date:

Signed Trainee:

Signed Trainer:

LEVELS OF COMPETENCE

- Level 1 Needs training to perform the task
- Level 2 Needs supervision in performing the task
- Level 3 Competent to perform the task unsupervised
- Level 4 Competent to train others to perform the task