anastomosis without supporting reconstruction of the levator ani muscle. Three thread turns are made without tension on No. 5-8 and only then the stitch is gradually tightened. The anastomosis at No. 8-12 is completed, and the stump of the Santorini plexus is sutured ventral to the urethra. The anastomosis is closed with the remainder of the first suture from No. 5 in the ventral direction to No. 12. The needles of both sutures are cut and both ends of the self-anchoring sutures are still tied.

Comment on the technique: The methodology has been used for over 10 years in more than 2,000 cases with satisfactory functional results, but the results have not been analysed in a high quality study. We do not routinely perform posterior reconstruction, this is also a given historically, when we did not perform it even in open procedures and we did not have more frequent complications of urinary continence. We perform posterior supportive reconstruction only very exceptionally when there is a large spacer defect after removal of the prostate, and in this case our intention is to reduce the tension of the subsequent anastomosis. We perform the actual interruption of the urethra at the apex of the prostate with an effort to preserve the puboprostatic ligaments as much as possible, especially their distal fibres, which also go into the external bundle. By subsequently taking this area into a suture, we carry out a certain reconstruction of the suspension apparatus in the neck of the bladder and there is no decrease in this area. We consider this front-upper reconstruction to be more physiological than performing a routine posterior support reconstruction. Our functional results, including economic aspects, have not forced us to change our strategy for more than 10 years.

Conclusion: The video presents one of the possible variants of urethrovesical anastomosis during robotic-assisted radical prostatectomy.

KEY WORDS

Prostate cancer, prostatectomy robot, uretrovesical anastomosis.

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