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Modification of the Kock's Pouch for Bladder Replacement

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Aim. To describe a modification of the Kock's pouch and present our clinical experience in its application.

Method. After isolating an adequate ileal segment, the bowel is split by a longitudinal incision, with both ends remaining unopened for about 3-4 cm in length. Previously anastomozed ureters are inserted into the proximal end so that a nipple valve is created. The distal unsplit end serves for a direct anastomosis with the urethra. During the past 9 years, this surgery was performed in 41 patients who underwent radical cystectomy due to invasive carcinoma. Seventeen patients died for unknown reasons or were lost to follow-up. The remaining 24 were included in the follow-up for a period of 7 months to 6 years post surgery.

Results. Half of the patients included in the follow-up urinated spontaneously, with post void residuals less than 120 mL and no need for catheterization. Four patients did not urinate spontaneously and needed continuous catheterization, whereas 8 patients had post void residuals of 150-200 mL and needed catheterization once a day or once a week. None of the patients had a stricture at the site of ureteroileal anastomosis.

Conclusion. We believe that our modification of the Kock's pouch makes the uretero-intestinal anastomosis much easier to perform; both ureters are inserted into the unsplit bowel end, thus preventing reflux; anastomosis with the urethra is performed under visual control; and direct anastomosis of widely opened distal end of the bowel reduces the possibility of scar stenosis.

Key words: bladder; bladder neoplasms; cystectomy; surgical anastomosis; uretherostomy; urinary diversion

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