Open prostatectomy for the treatment of bladder outlet obstruction is rarely performed today because of the advances in technique of transurethral prostatectomy and anesthesia and α-blocker medical therapy for benign prostatic hyperplasia (BPH). Nevertheless, the urological surgeon must be familiar with the indications and techniques for performing open prostatectomy. The main techniques for performing open prostatectomy consist of the transvesical suprapubic prostatectomy and simple retropubic prostatectomy. Today, indications for open prostatectomy consist mainly of situations of failed medical therapy for BPH as well as situations in which the urologist considers transurethral surgery to be of increased risk to the patient compared with open prostatectomy (Table 32.1).

**OPEN PROSTATECTOMY**

**Preparation**

The patient should be given informed consent and counseled regarding the risk for blood loss, infection, incontinence, and erectile dysfunction. Blood should be available during the surgery. Preexisting azotemia, urinary tract infection, and dehydration should be corrected if present preoperatively. Open prostatectomy, as an elective procedure, should proceed only after the patient has been screened for cardiovascular, pulmonary, and coagulation disorders as indicated. Spinal anesthesia is the preferred method of anesthesia unless contraindicated. The suprapubic transvesical approach is preferred over the simple retropubic approach in situations where concomitant intravesical or bladder procedures are planned or anticipated and where a large intravesical prostatic component is present. Patients on anticoagulation medications present a special challenge and should have anticoagulation discontinued 5–7 d preoperatively following consultation with the medical physician and/or cardiologist.

**Instrumentation**

The operating room should have available a basic laparotomy set along with self-retaining retractors with bladder blades, ureteral catheters, indigo carmine or methylene blue, vaginal packs, sponge sticks, hooked 11 or 15 blade scalpel, large-bore three-way urethral catheter with 30-cc or greater balloon, two-way urethral catheter with 5-cc balloon, and continuous bladder normal saline irrigation.

**SUPRAPUBIC PROSTATECTOMY**

**Positioning of the Patient**

The patient is most commonly placed supine on the operating table, or alternatively may be positioned in the low litotomy position to allow placement of a third assistant or nurse. A lumbar role may aid exposure to the retropubic area, and additional exposure may be obtained with gentle breakage of the table. The right-handed surgeon should stand on the left side of the patient. Following anesthesia, the abdomen and penis are prepped and draped, and the bladder is catheterized with a urethral
catheter using sterile technique (16–22 French) and the urine sent for culture and sensitivity. The bladder is then distended with antibiotic irrigation to capacity and the urethral catheter clamped.

**Incision**

Most urologists utilize a vertical midline incision (Fig. 32.1A), but a transverse incision works as well. Using the vertical midline approach, the skin is incised with a knife from just below the umbilicus to the pubic symphysis (Fig. 32.1A) over the distended palpable bladder (Fig. 32.1B). The rectus fascia is opened in the midline with electrocautery to expose the perivesical fat, space of Retzius, and detrusor muscle. A self-retaining retractor is then positioned to facilitate exposure of the distended bladder. At this point, O-chromic