ITALY'S BEST SPECIALIZED HOSPITAL
UROLOGY
Newsweek
2026
PADOVA

Derivazioni urinarie incontinenti

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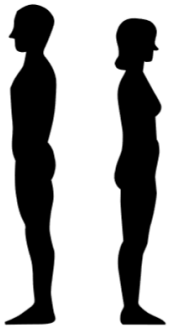
Urologo/Andrologo

Padova 12.12.2025

Epidemiologia tumore della vescica

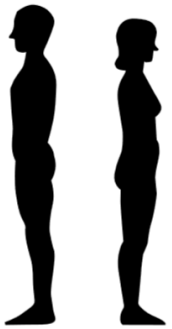
Estimated New Cases

Male			Female		
Prostate	299,010	29%	Breast	310,720	32%
Lung & bronchus	116,310	11%	Lung & bronchus	118,270	12%
Colon & rectum	81,540	8%	Colon & rectum	71,270	7%
Urinary bladder	63,070	6%	Uterine corpus	67,880	7%
Melanoma of the skin	59,170	6%	Melanoma of the skin	41,470	4%
Kidney & renal pelvis	52,380	5%	Non-Hodgkin lymphoma	36,030	4%
Non-Hodgkin lymphoma	44,590	4%	Pancreas	31,910	3%
Oral cavity & pharynx	41,510	4%	Thyroid	31,520	3%
Leukemia	36,450	4%	Kidney & renal pelvis	29,230	3%
Pancreas	34,530	3%	Leukemia	26,320	3%
All sites	**1,029,080**		**All sites**	**972,060**	



Estimated Deaths

Male			Female		
Lung & bronchus	65,790	20%	Lung & bronchus	59,280	21%
Prostate	35,250	11%	Breast	42,250	15%
Colon & rectum	28,700	9%	Pancreas	24,480	8%
Pancreas	27,270	8%	Colon & rectum	24,310	8%
Liver & intrahepatic bile duct	19,120	6%	Uterine corpus	13,250	5%
Leukemia	13,640	4%	Ovary	12,740	4%
Esophagus	12,880	4%	Liver & intrahepatic bile duct	10,720	4%
Urinary bladder	12,290	4%	Leukemia	10,030	3%
Non-Hodgkin lymphoma	11,780	4%	Non-Hodgkin lymphoma	8,360	3%
Brain & other nervous system	10,690	3%	Brain & other nervous system	8,070	3%
All sites	**322,800**		**All sites**	**288,920**	



Estimates are rounded to the nearest 10, and cases exclude basal cell and squamous cell skin cancers and in situ carcinoma except urinary bladder. Estimates do not include Puerto Rico or other US territories. Ranking is based on modeled projections and may differ from the most recent observed data.

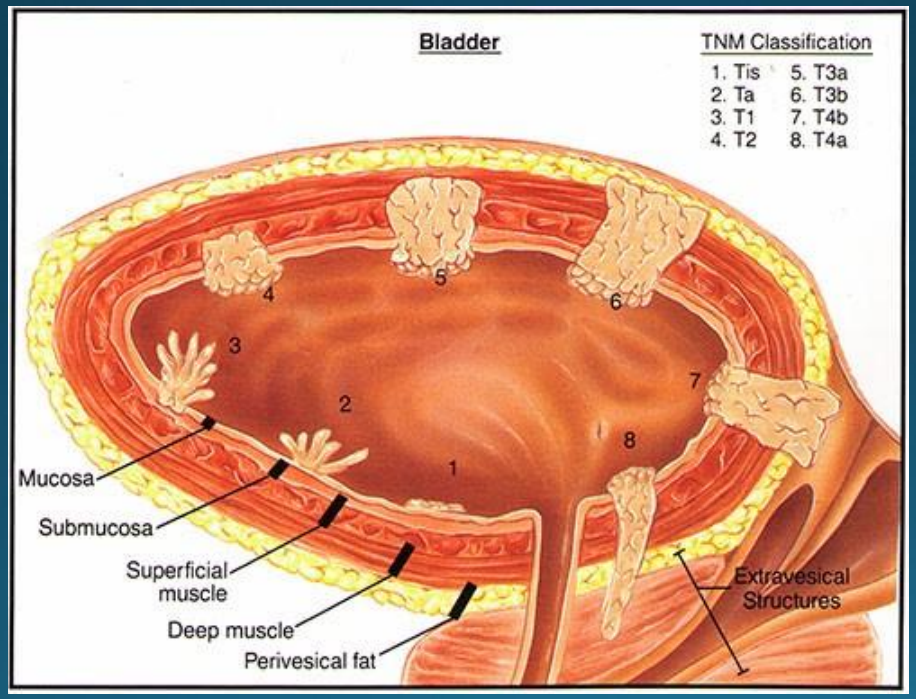
Bladder cancer (BC) is the seventh most commonly diagnosed cancer in the male population worldwide, and it is the tenth when both genders are considered

Siegel, CA Cancer J Clin. 2025

Epidemiologia tumore della vescica

75% dei casi → non muscolo invasiva (NMIBC)

25% dei casi → muscolo-invasiva



Patogenesi

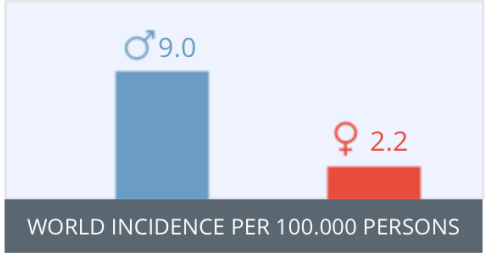
- ✓ ***FUMO DI SIGARETTA***
- ✓ ***AGENTI CHIMICI INDUSTRIALI (COLORANTI, GOMME, COLLE,...)***
- ✓ ***SCHISTOSOMA (ISTOTIPO SQUAMOSO)***
- ✓ ***ESPOSIZIONI A RADIAZIONI IONIZZANTI***

Patogenesi

- **incidenza** → M:F=4:1
- **mortalità** → F>M

Gender differences

Women have an up to four times lower bladder cancer incidence rate than men. However, women are generally diagnosed with more advanced disease at presentation and have less favorable outcomes after treatment than men.



♀ LOWER INCIDENCE

The lower incidence rate among women could be explained by **lower smoking prevalence** and **less occupational exposures to carcinogens** compared to men, and because women have a **higher expression of enzymes** taking part in the degradation of carcinogens.

♀ HIGHER MORTALITY

Differences in prognostic factors between men and women explain only 30% of gender-related differences in bladder cancer mortality, so the reason behind the higher mortality rate remains unclear.

Suggested causes are the **unequal access to health care, delays in diagnosis and treatment, treatment efficacy and disease biology.**[4,5]

♀ LATE DIAGNOSIS

The reason that women generally have more advanced tumours at the time of diagnosis may be the fact that they have a **high frequency of urinary tract infections**. This makes them significantly less likely to undergo a timely and complete hematuria evaluation.

Therefore, the guideline-based approach for patients with hematuria should be followed regardless of gender!

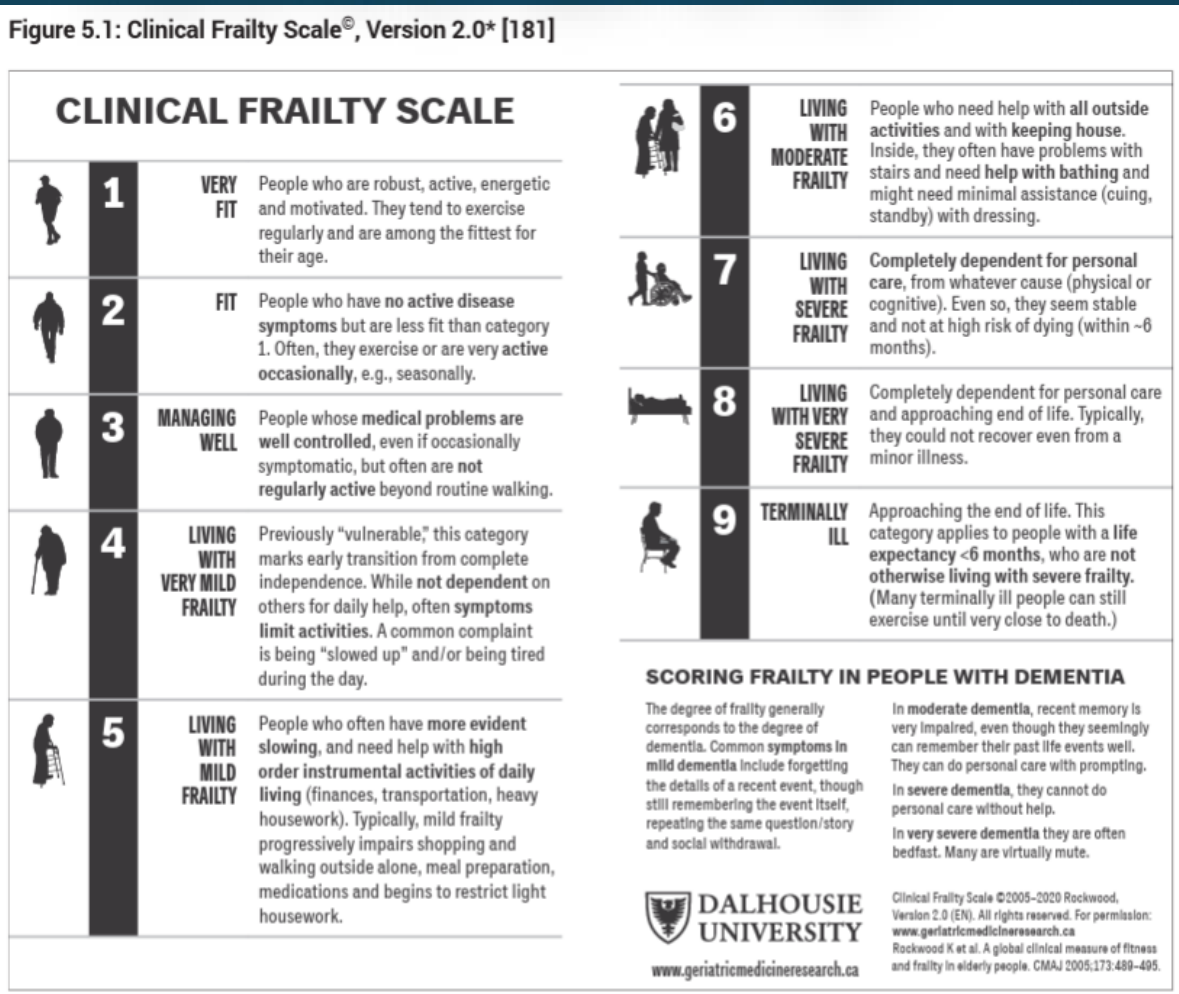
EAU Guidelines 2025

https://www.youtube.com/watch?v=LolDr11m50g

APS Associazione
PaLiNUro
PAZIENTI LIBERI DALLE NEOPLASIE UROTELIALI

Clinical Frailty Scale

Figure 5.1: Clinical Frailty Scale©, Version 2.0* [181]



*Permission to reproduce the Clinical Frailty Scale© has been granted by the copyright holder.

Charlson Score

5.1: Clinical Frailty Scale©, Version 2.0* [181]

LINICAL FRAILTY SCALE

1	VERY FIT	People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.
2	FIT	People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g., seasonally.
3	MANAGING WELL	People whose **medical problems are well controlled**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.
4	LIVING WITH VERY MILD FRAILTY	Previously "vulnerable," this category marks early transition from complete independence. While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up" and/or being tired during the day.
5	LIVING WITH MILD FRAILTY	People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.
6	LIVING WITH MODERATE FRAILTY	People who need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.
7	LIVING WITH SEVERE FRAILTY	**Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).
8	LIVING WITH VERY SEVERE FRAILTY	Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.
9	TERMINALLY ILL	Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise living with severe frailty.** (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

In **very severe dementia** they are often bedfast. Many are virtually mute.

DALHOUSIE UNIVERSITY
www.geriatricmedicineresearch.ca

Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

sion to reproduce the Clinical Frailty Scale© has been granted by the copyright holder.

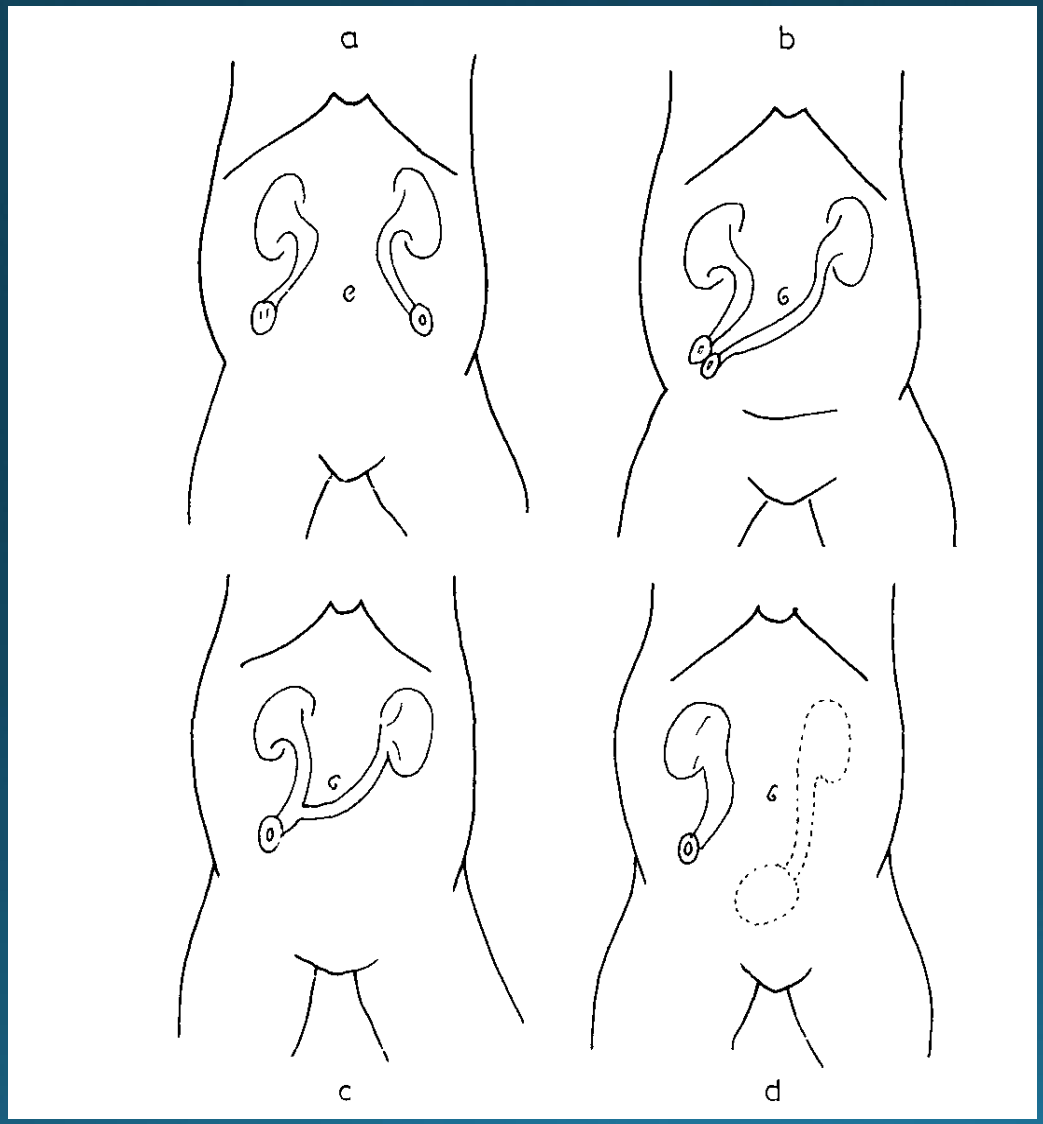
Comorbidity scales, anaesthetic risk classification and geriatric assessment

e of comorbidity scales has been developed [182], seven of which have been validated [183-189]. The n Comorbidity Index (CCI) ranges from 0 to 30 according to the importance of comorbidity described levels and is calculated by healthcare practitioners based on patients' medical records. The score has idely studied in patients with BC and found to be an independent prognostic factor for peri-operative y [190, 191], overall mortality [192], and CSM [164, 193-195]. Only the age-adjusted version of the CCI related with both cancer-specific and other-cause mortality [196]. The age-adjusted CCI (Table 5.3) is the idely used comorbidity index in cancer for estimating long-term survival and is easily calculated [197].

Health assessment of oncology patients must be supplemented by measuring their activity level. ann *et al.*, have shown that there is no correlation between morbidity and competitive activity level [198]. stern Cooperative Oncology Group (ECOG) performance status (PS) scores and Karnofsky index have lidated to measure patient activity [199]. Performance score is correlated with patient OS after RC [194] liative chemotherapy [200-202].

s who have screened positive for frailty or cognitive impairment benefit from an assessment by a cian. This allows identification of geriatric syndromes and any scope for optimisation. The most te protocol is the Comprehensive Geriatric Assessment (CGA) [203] which is useful in the care of cancer s [204]. In BC, the CGA has been used to adapt gemcitabine chemotherapy in previously untreated older s with advanced BC [205].

Ureterocutaneostomia



Ureterocutaneostomia

THE JOURNAL OF UROLOGY
Vol. 88, No. 6 December 1962

BUTTERFLY CUTANEOUS URETEROSTOMY

JACK LAPIDES

From the Section of Urology, Department of Surgery, University of Michigan Medical School, Ann Arbor, and Wayne County General Hospital, Eloise, Mich.

It is believed that bilateral cutaneous ureterostomy is the best form of supravesical urinary diversion provided that both ureters can be exteriorized together[1, 2] and permanent intubation of the ureters avoided. Cutaneous ureterostomy is superior to ureteroenteric anastomosis in that the operative procedure is simple and the postoperative complications, immediate and delayed, can be markedly minimized.

The literature on ureterocutaneous anastomosis would seem to indicate that the primary difficulty with this operation has been stricture formation at the skin and fascial levels. Our interest in cutaneous ureterostomy was stimulated initially by our success in preventing stricture of the stomas in patients with cutaneous vesicostomy and abdominal neourethrostomy. Stricture formation in these instances was obviated with the use of a skin flap, turned downward through the stoma to be incorporated into the wall of the vesicocutaneous fistula.[3]

Our research on cutaneous ureterostomy began in 1958 and is still in progress. Observations made during this period indicate that the main difficulty in cutaneous ureterostomy pertains to blood supply. When a ureter is transected near the ureterovesical junction and mobilized for transplantation to the anterior abdominal wall, the arterial blood supply from the vesical, iliac and aortic vessels is usually interrupted. If the contrast, hypertrophied, thick-walled ureters can be transplanted to skin without any danger of necrosis of the distal segment. DeVries[4] and Humphreys[5] observed the same phenomenon and concluded that transplantation of a normal ureter to skin was precarious regardless of the technique used. We are entirely in accord with this conclusion, and at the present time do not

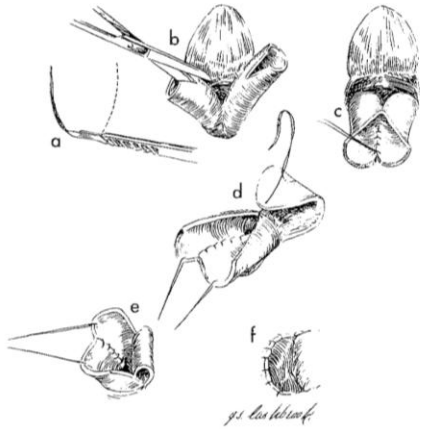


FIG. 1. Cutaneous ureterostomy technique using one skin flap. *a*, Formation of skin flap. *b*, Spatulation of ureters. *c*, Ureteroureteral anastomosis. *d*, *e* and *f*, ureterocutaneous anastomosis.

Ureterocutaneostomia

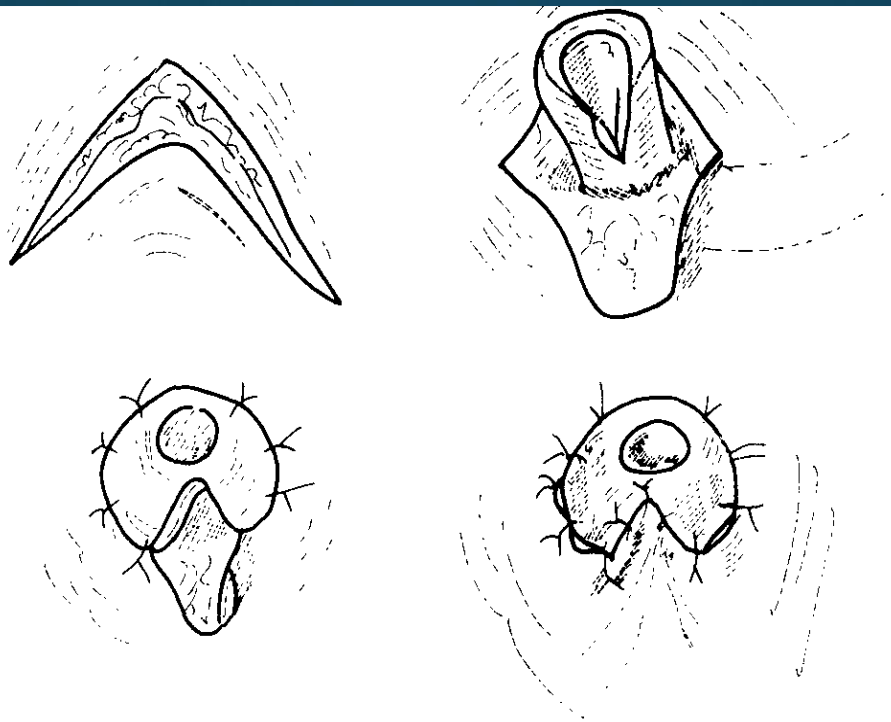
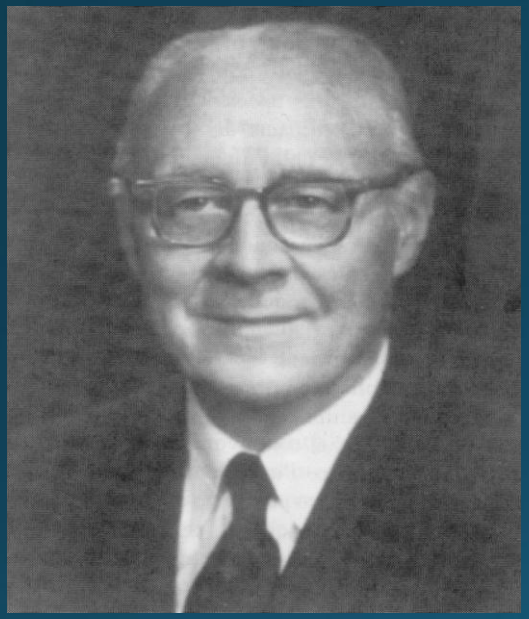


Fig. 3. Implantation of ureter according to Eckstein; useful in cases where the ureter can be easily passed to the cutaneous level

Condotto ileale sec. Bricker (1950)

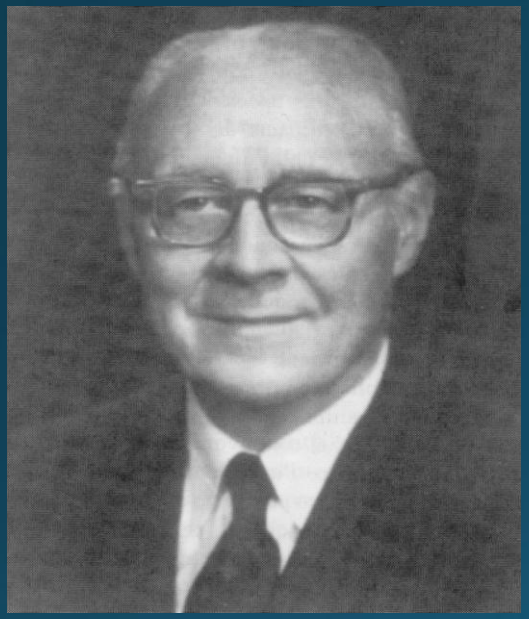


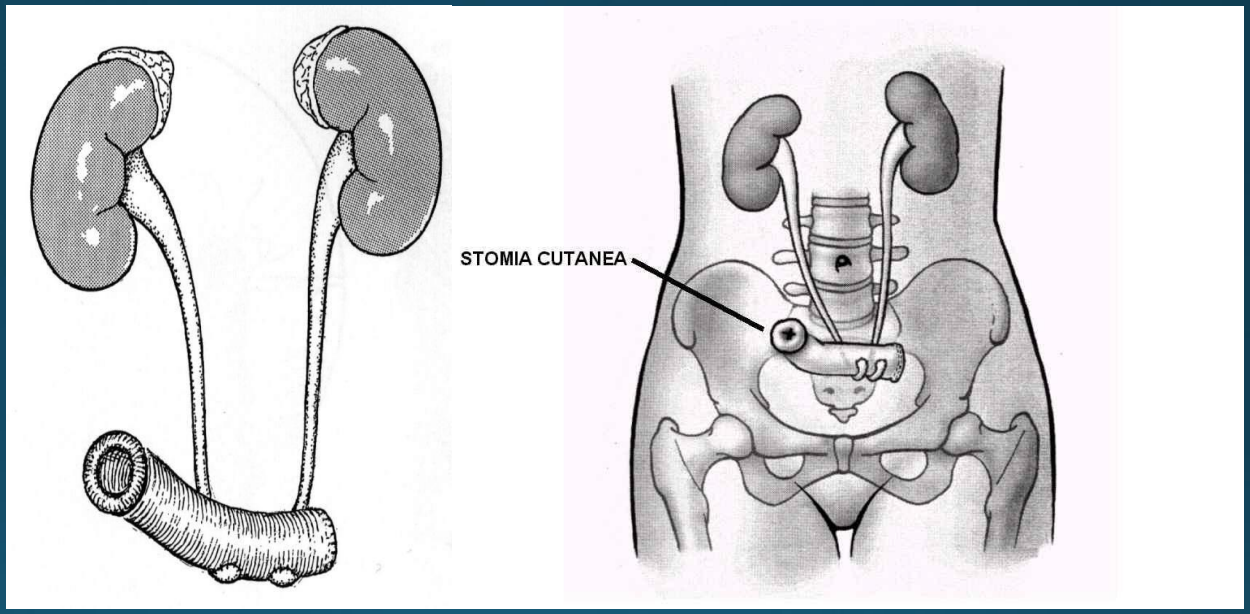
BLADDER SUBSTITUTION AFTER PELVIC EVISCERATION

EUGENE M. BRICKER, M.D., F.A.C.S.*

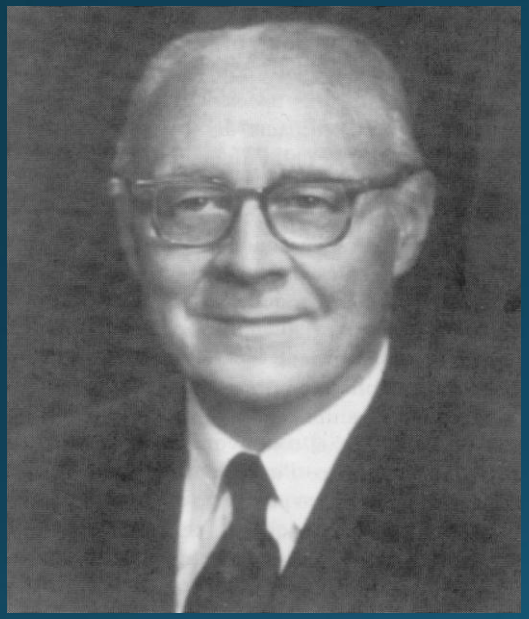
THE problem of developing a suitable substitute for the urinary bladder has been one that has intrigued surgeons intermittently for a good many years. Practically all anatomical possibilities were exhausted at the beginning of this century. Hinman and Weyrauch[1] have reviewed the various attempts at bladder substitution by uretero-enterostomy. Apparently the first attempt to divert the urinary stream into an isolated segment of ileum and ascending colon was done by Verhoogen[2] in 1908. Such attempts were subsequently discarded because of the prohibitive mortality and the problem of ureteral disposal following cystectomy was solved for many years by the simple implantation of the ureters into the intact sigmoid colon. This procedure is still the one of choice following cystectomy and it will probably remain the procedure of choice in cases in which the sigmoid and rectum can be preserved. However, the recent development of pelvic evisceration as a therapeutic procedure has focused attention again on the problem of what to do with the ureters in cases in which this procedure is used, since the sigmoid colon and rectum are not available as a receptacle.

Condotto ileale sec. Bricker



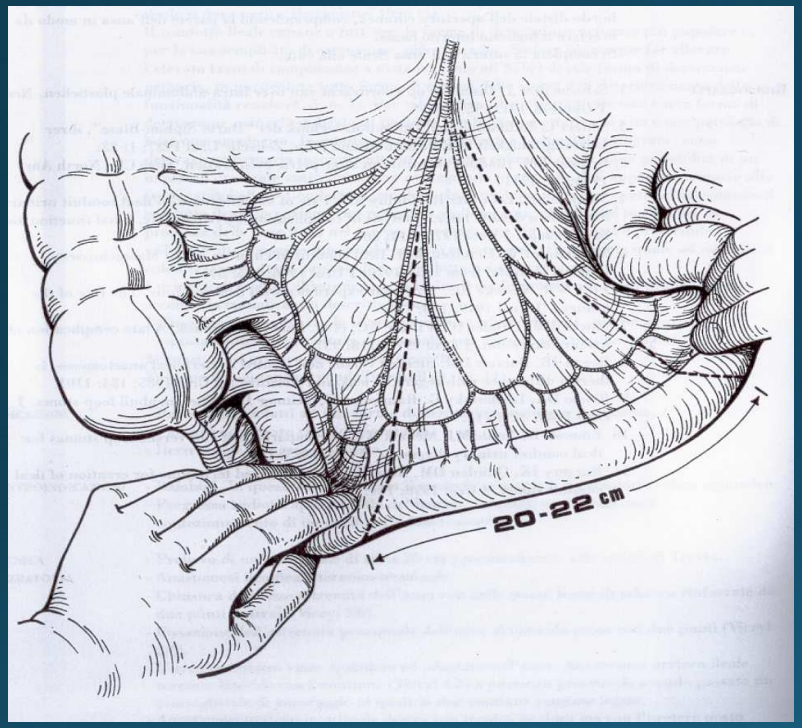


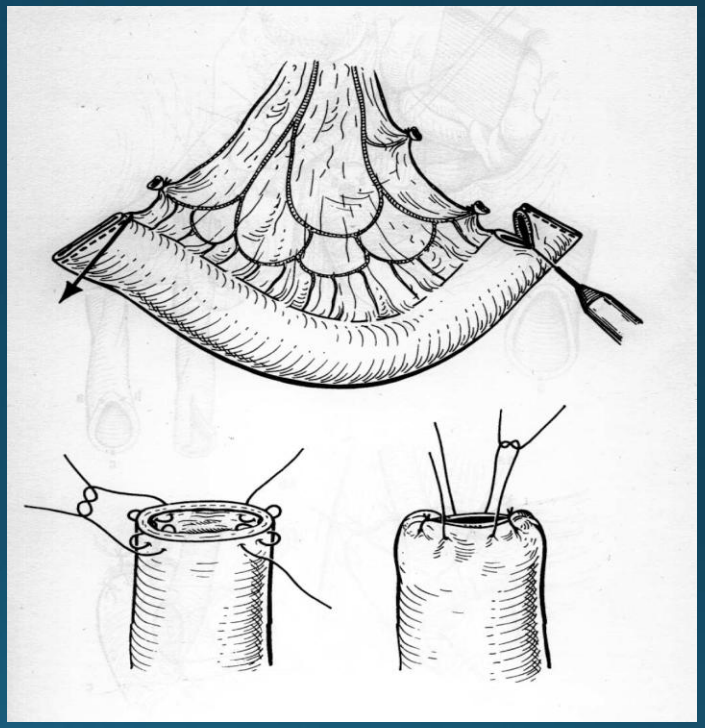
Condotto ileale sec. Bricker



and after complete hemostasis is obtained, the bladder substitution procedure is done. The details of this procedure are depicted in accompanying illustrations (Figs. 436, 437 and 438). It consists essentially of isolation of a segment of terminal ileum about 4 or 5 inches from the ileocecal junction and about 6 to 8 inches in length. The continuity of the gastrointestinal tract is reestablished by end-to-end anastomosis of the ileum, the proximal end of the isolated segment is closed and the distal end is prepared for deliverance through an opening in the right side of the abdomen, the site of which has been selected prior to opening the abdomen. This site must be optimum for the application of a Rutzen bag. The ureters are then anastomosed to the segment of ileum by the technic illustrated, the distal end of the segment is delivered through the accessory opening in the right side of the abdomen and the right lumbar gutter is completely obliterated as shown. We believe that obliteration of the lumbar gutter and suture of the segment of ileum in such a manner that the bowel cannot herniate lateral to it is an important step in the procedure. The abdominal stoma is immediately opened and the mucosa of the exteriorized ileum is carefully sutured to the skin with interrupted fine catgut sutures. A catheter is inserted through the

Condotto ileale sec. Bricker

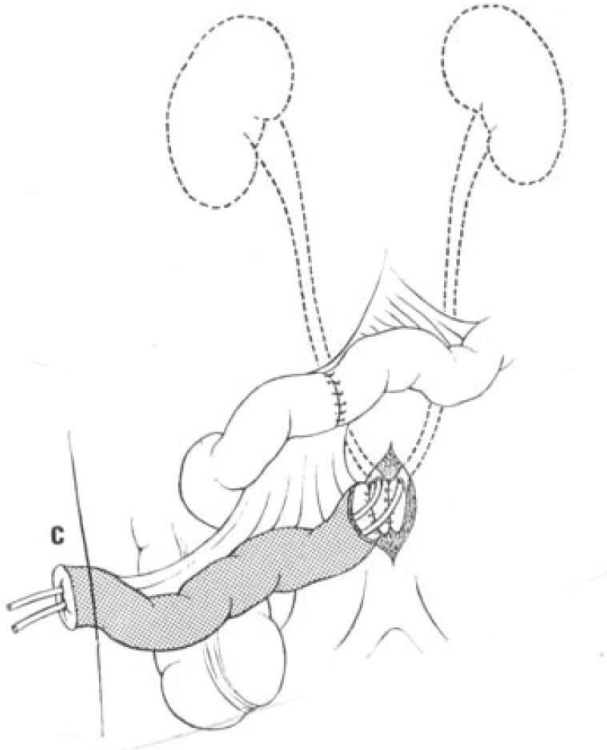




URETERIC DIVERSION USING A CONDUIT : A SIMPLIFIED TECHNIQUE

By D. M. WALLACE, M.S.

Royal Marsden Hospital, London

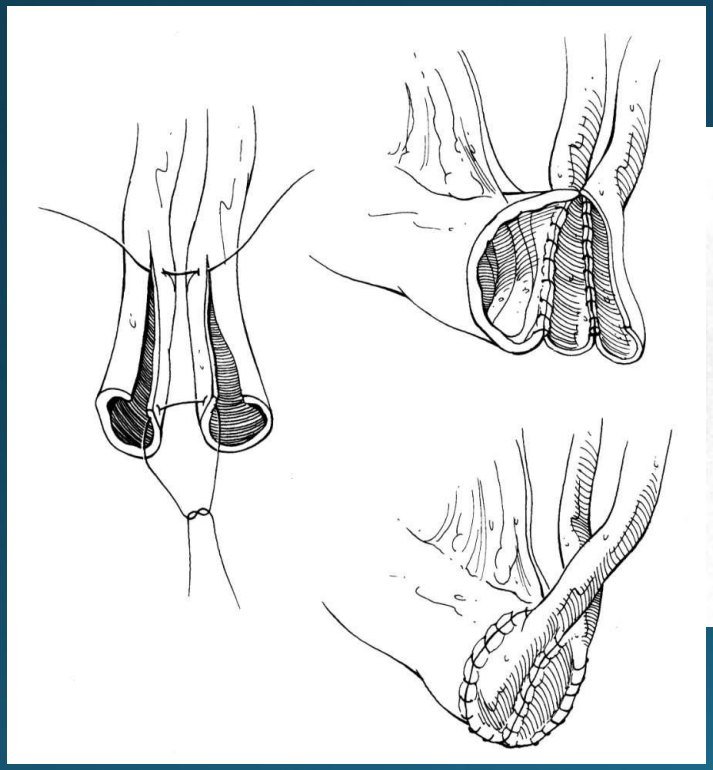


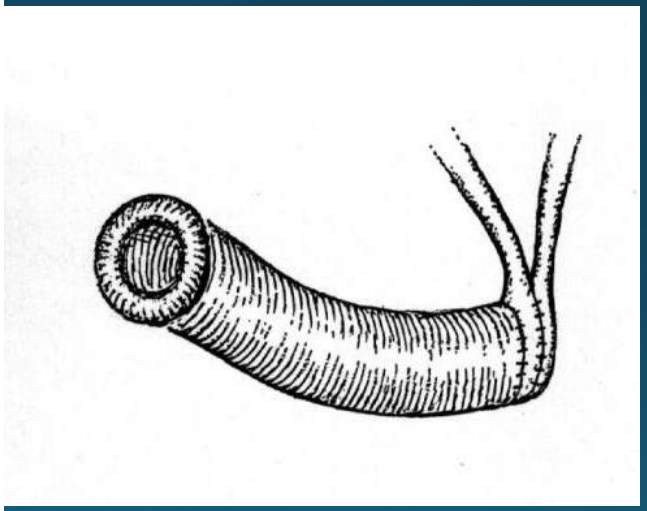
The positioning of the stoma demands meticulous attention. If placed too low, the skin crease in the groin will result in leakage, or in a pendulous abdomen the skin crease below the abdominal apron will also cause leakage. If the stoma is level with the iliac spine the belt will ride up and the flange pull on the stoma. If placed too near the umbilicus or an abdominal scar, leakage will be inevitable. Ideally, the patient should be fitted with whatever appliance is envisaged before operation so that the stoma site can be selected.

The care of the skin around the stoma requires constant attention. A dermatitis due to the appliance being too big and consequent pooling of urine around the stoma can be prevented by better choice of flange or by packing placed around the stoma to prevent accumulation of urine. The care of the flange and the method of adhesion is equally important ; some patients develop a sensitivity to adhesives, others prefer to have a flange which is watertight, but does not employ adhesives. Unless the urologist is prepared to take an interest in the after-care of the urinary stoma a certain number of his patients will find this an extremely unsatisfactory method of diversion.

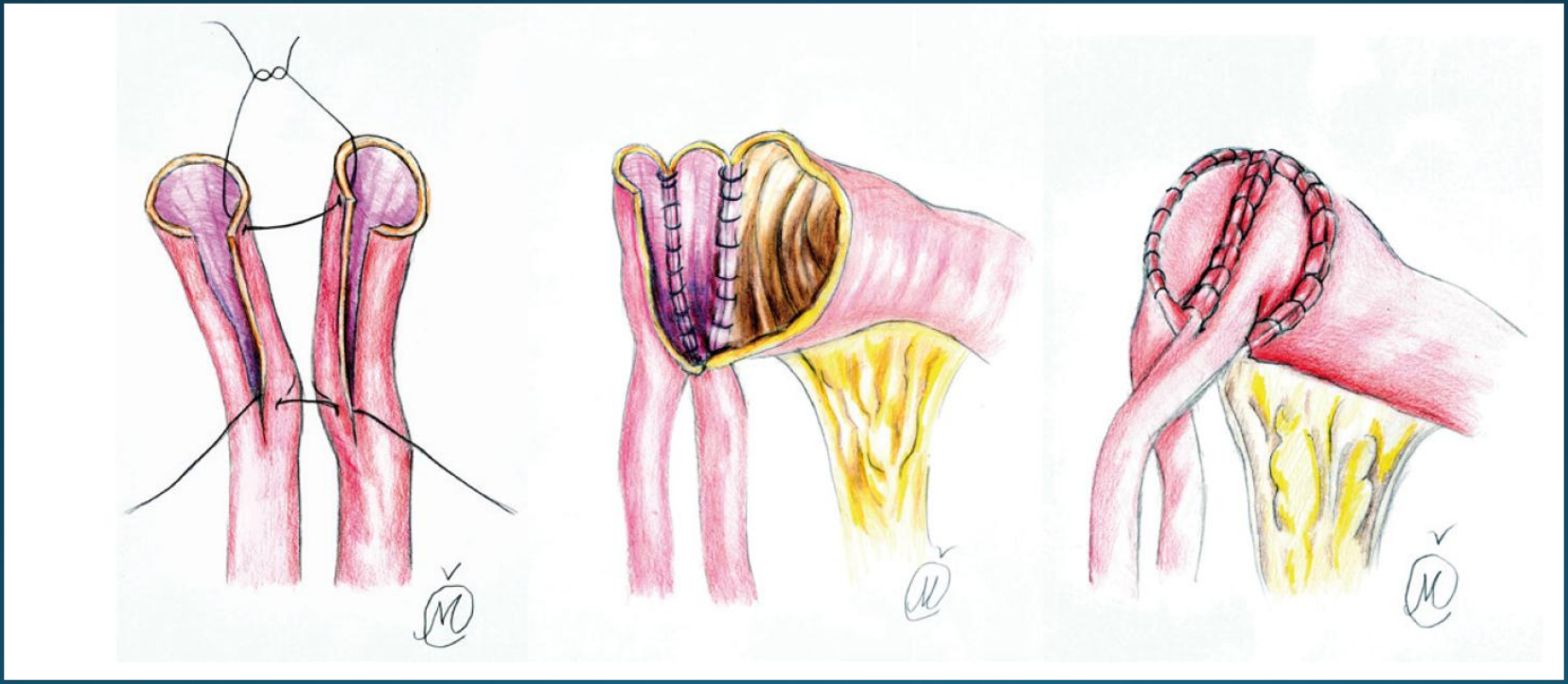
1966

Condotto ileale sec. Wallace



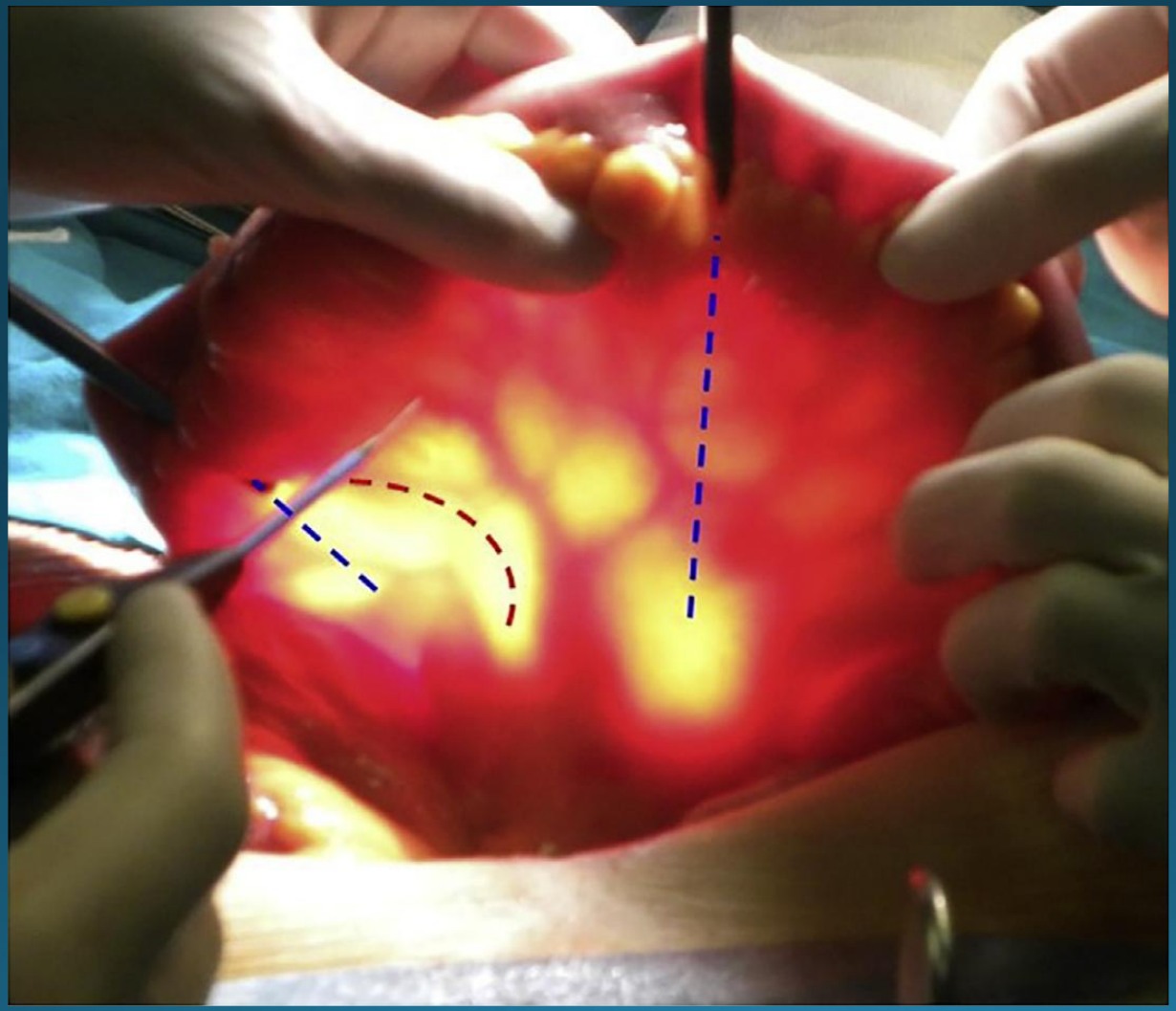


Condotto ileale sec. Wallace

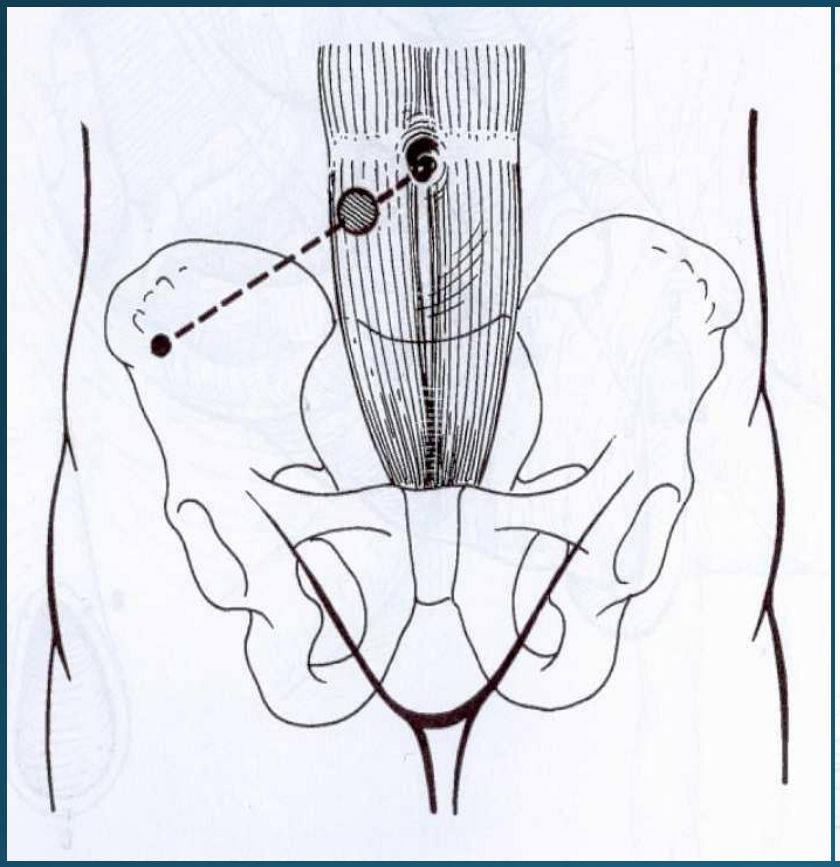


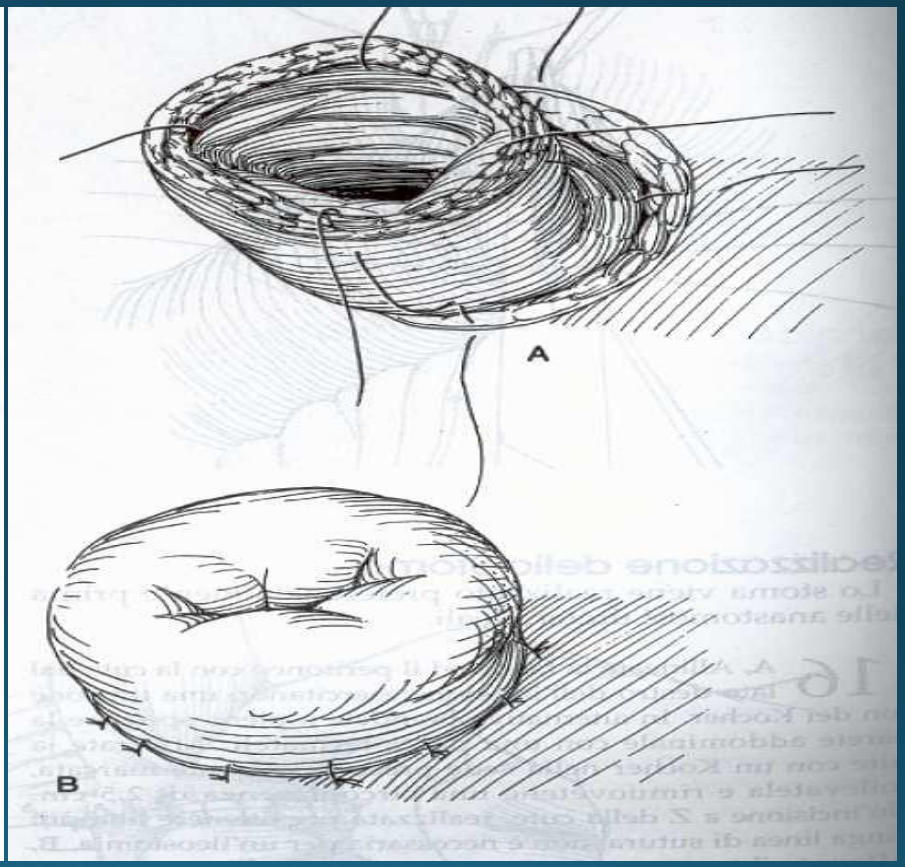
Derivazioni Urinarie non continenti

Scelta del tratto di ileo da utilizzare

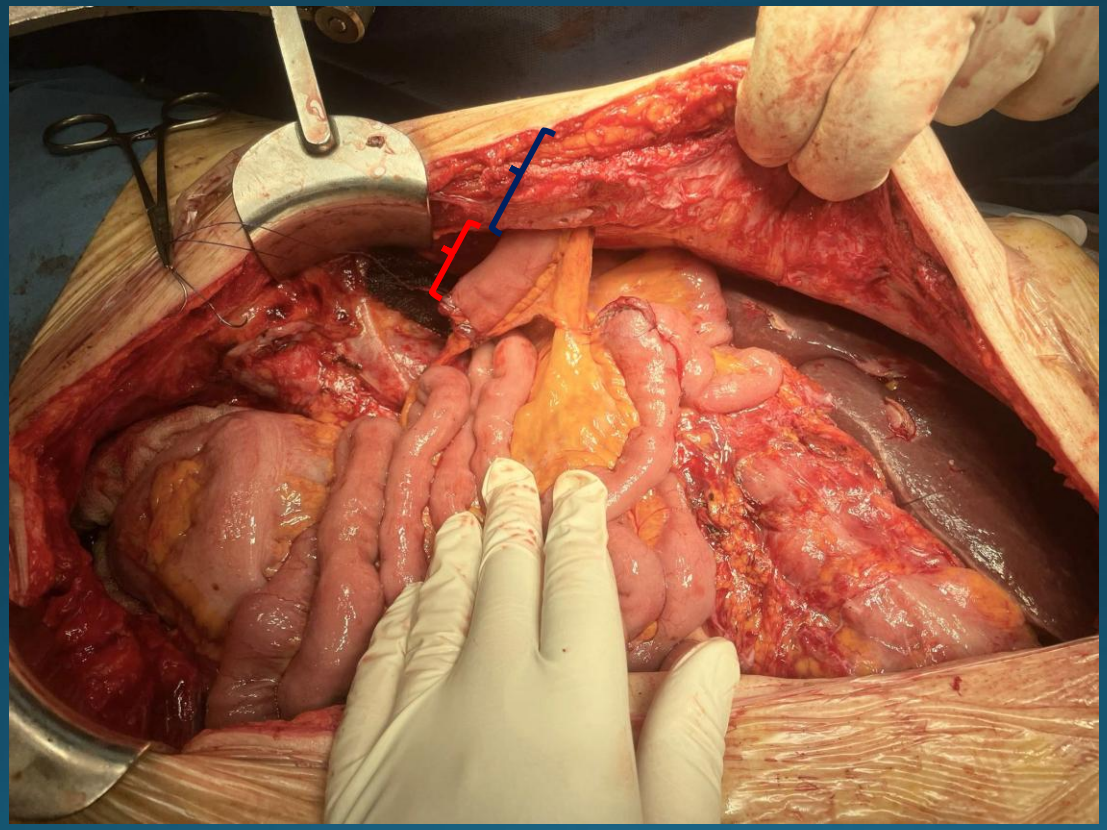


Stomia urinaria

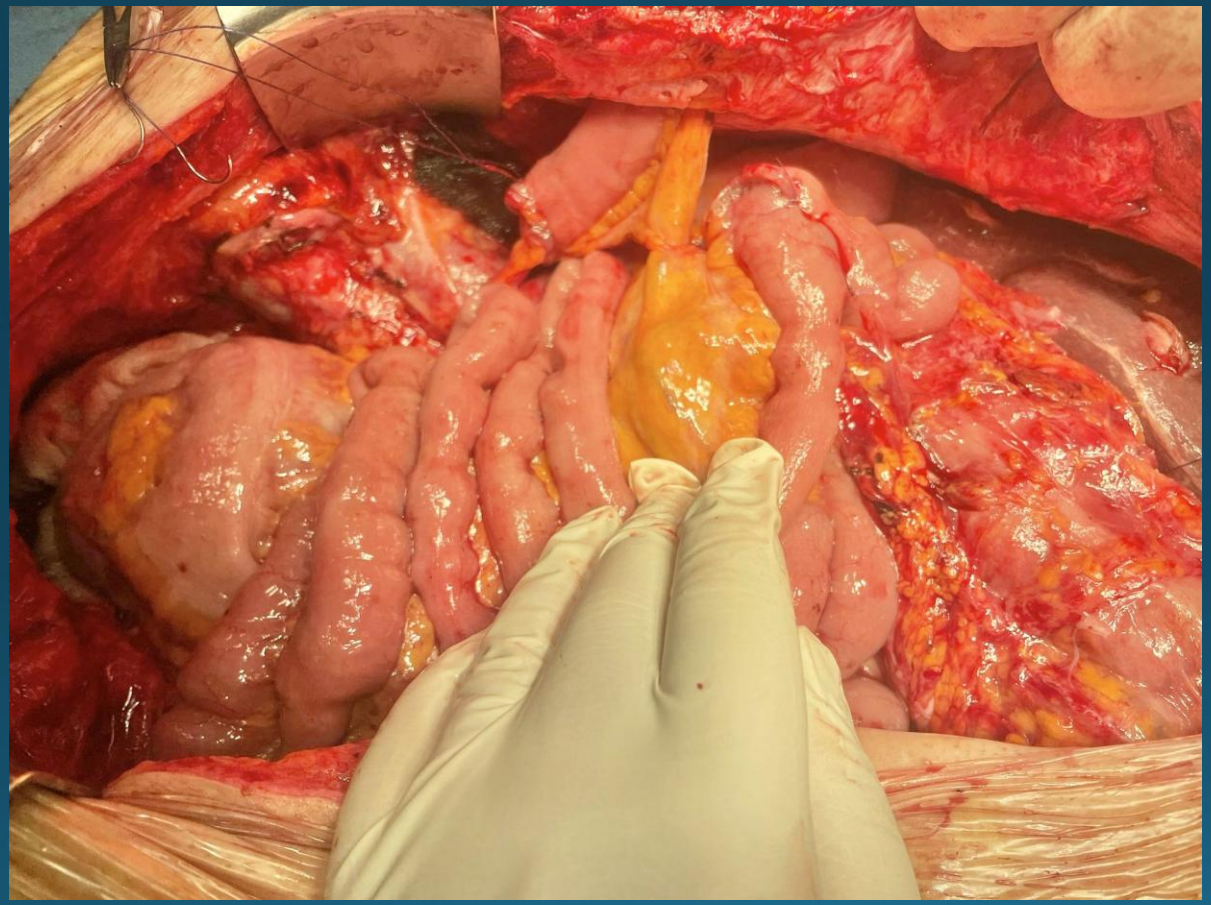




Derivazione urinaria esterna «open»

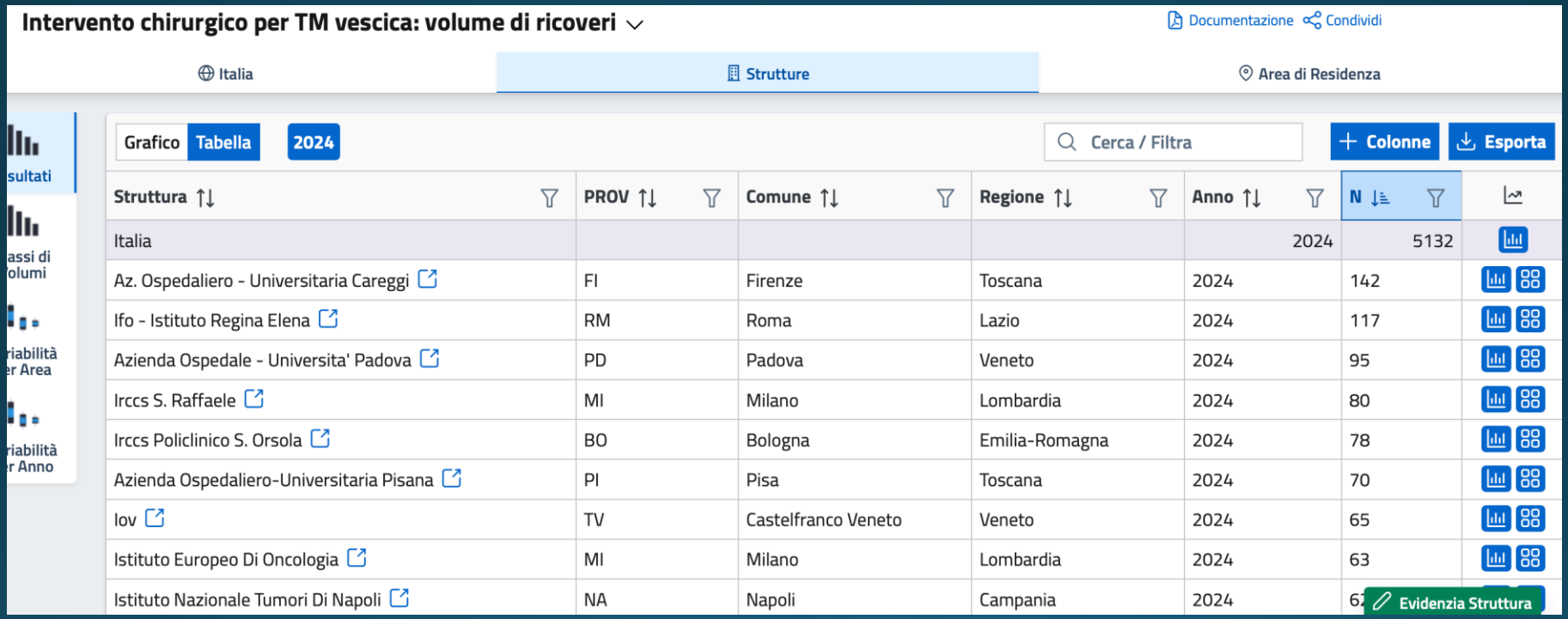


Derivazione urinaria esterna «open»



Stomia dopo tecnica «open»

I numeri delle cistectomie in Italia



Intervento chirurgico per TM vescica: volume di ricoveri

Documentazione · Condividi

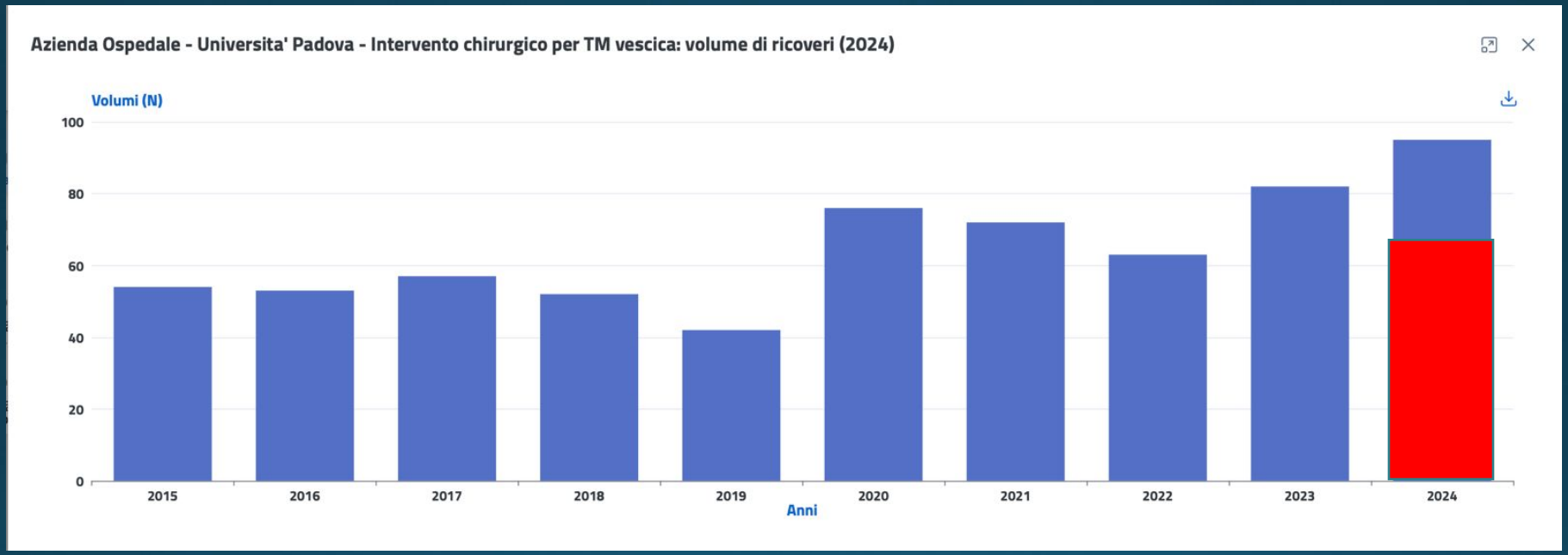
Italia | Strutture | Area di Residenza

Grafico | Tabella | 2024 | Cerca / Filtra | + Colonne | Esporta

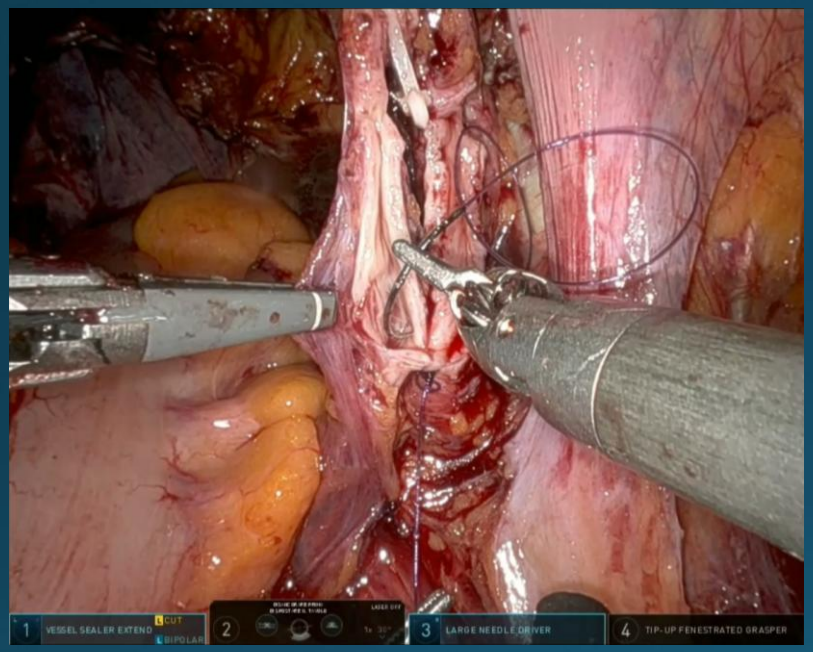
Struttura	PROV	Comune	Regione	Anno	N
Italia				2024	5132
Az. Ospedaliero - Universitaria Careggi	FI	Firenze	Toscana	2024	142
Ifo - Istituto Regina Elena	RM	Roma	Lazio	2024	117
Azienda Ospedale - Universita' Padova	PD	Padova	Veneto	2024	95
Irccs S. Raffaele	MI	Milano	Lombardia	2024	80
Irccs Policlinico S. Orsola	BO	Bologna	Emilia-Romagna	2024	78
Azienda Ospedaliero-Universitaria Pisana	PI	Pisa	Toscana	2024	70
Iov	TV	Castelfranco Veneto	Veneto	2024	65
Istituto Europeo Di Oncologia	MI	Milano	Lombardia	2024	63
Istituto Nazionale Tumori Di Napoli	NA	Napoli	Campania	2024	62

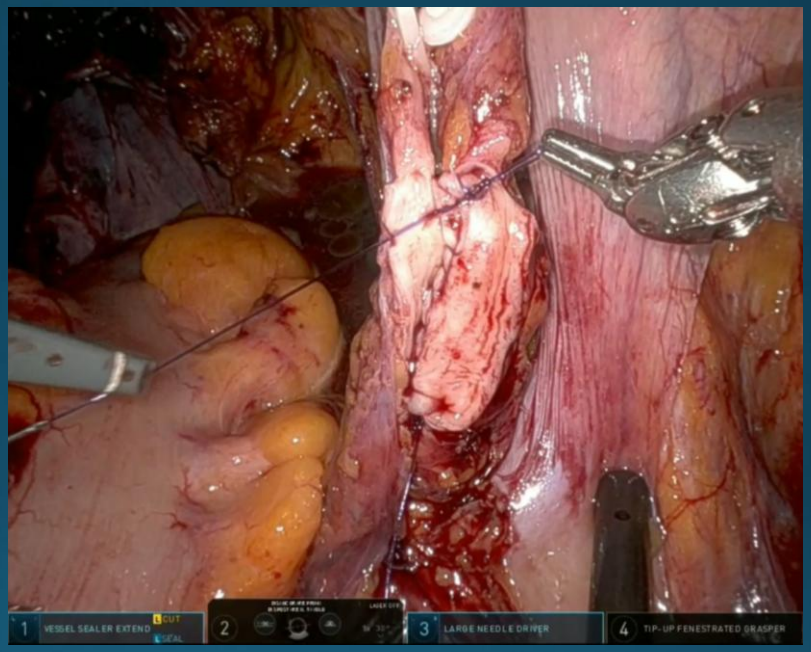
Evidenzia Struttura

La rivoluzione «robotica»

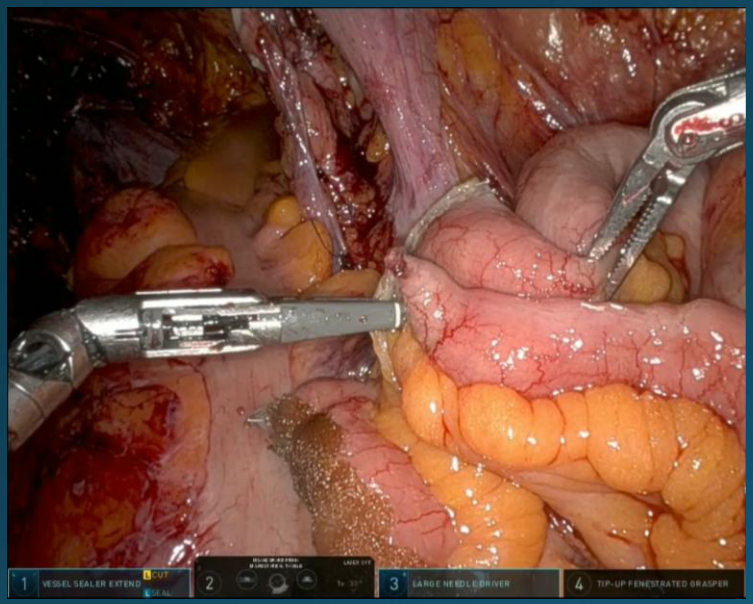


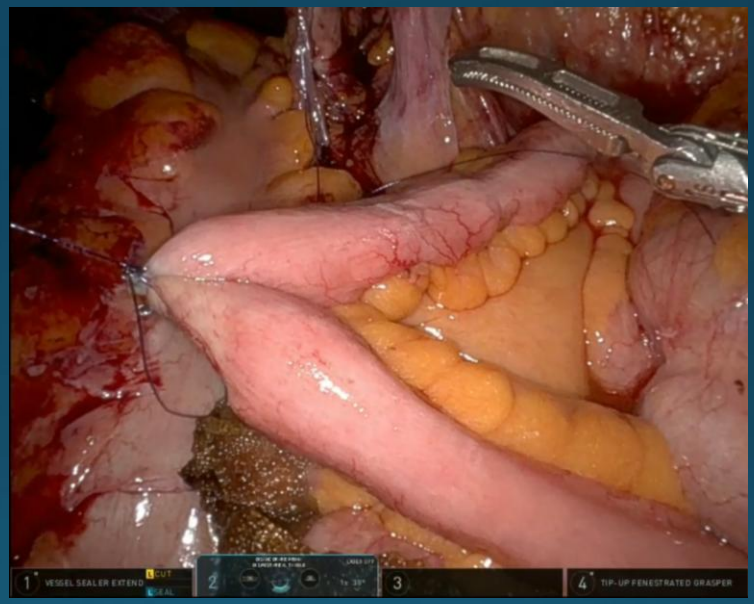
Tecnica «robotica» del condotto ileale





Tecnica «robotica» del condotto ileale





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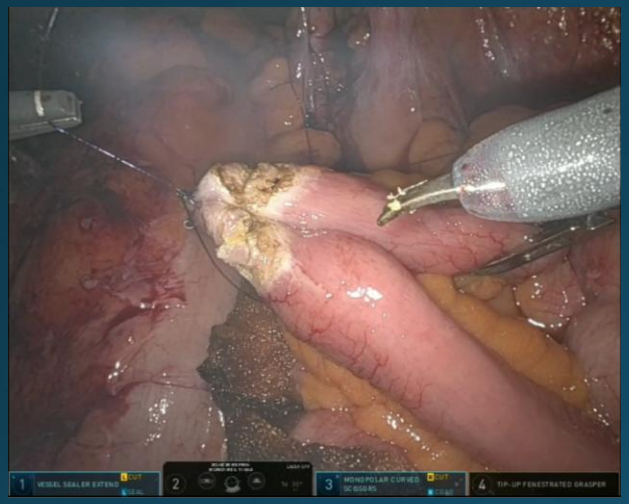
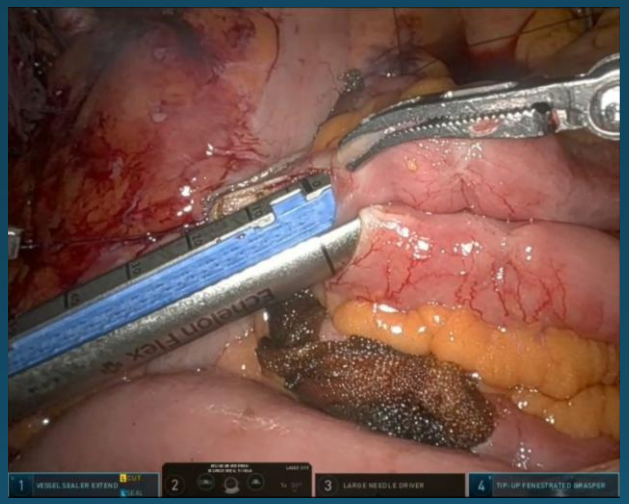
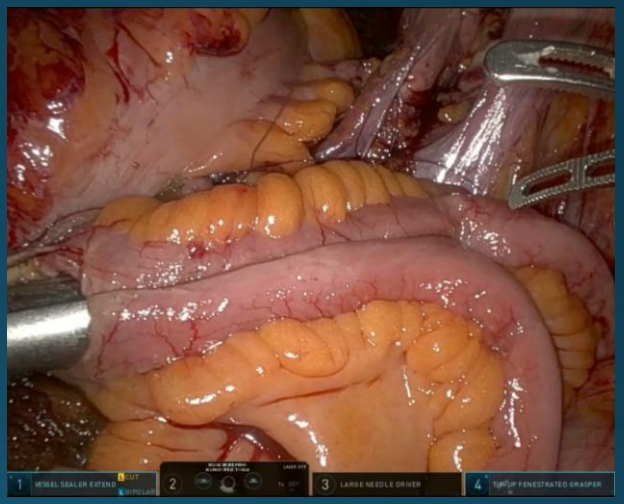
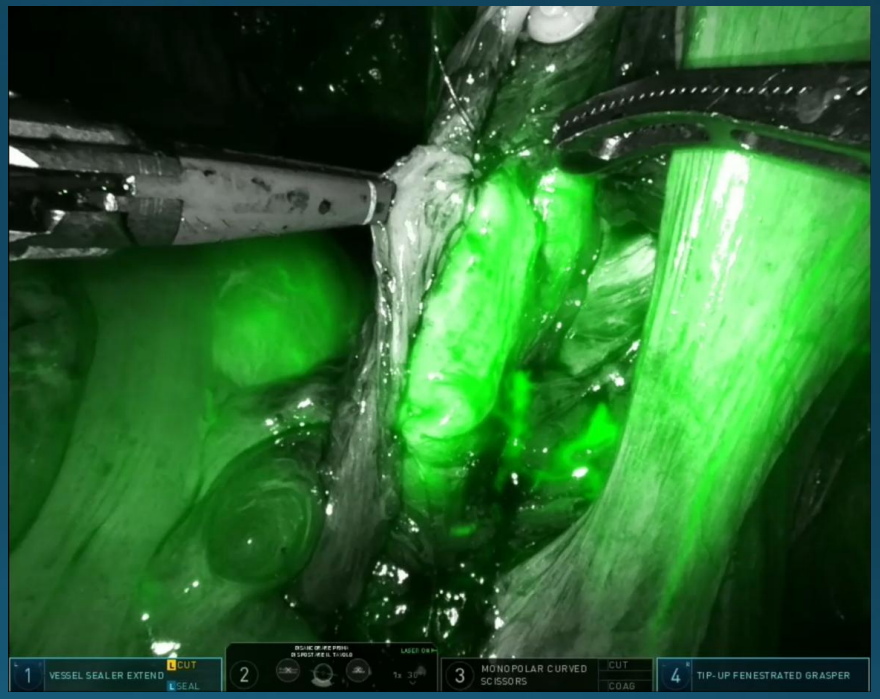






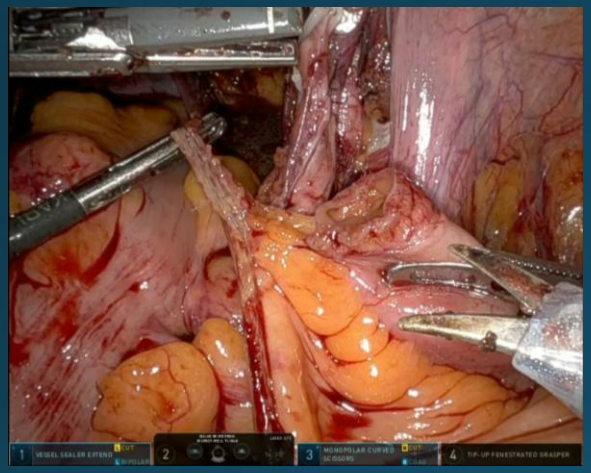
Tecnica «robotica» del condotto ileale

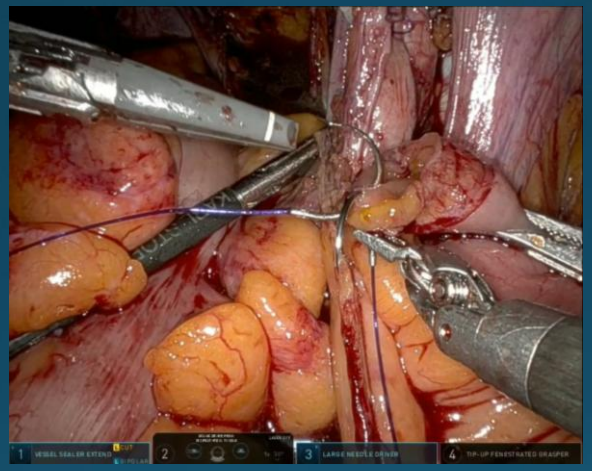
segmento ileale e anastomosi intestinale

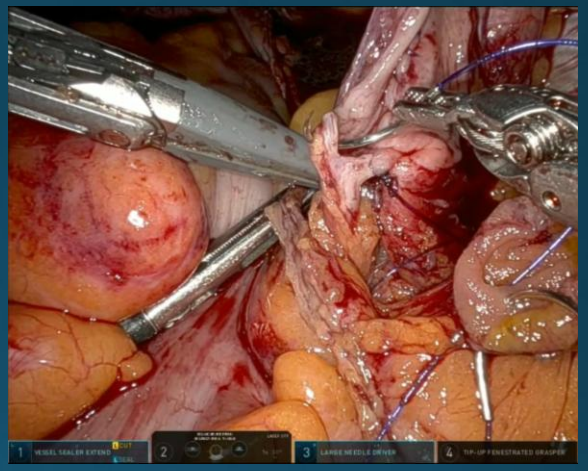


piatto ureterale

Tecnica «robotica» del condotto ileale







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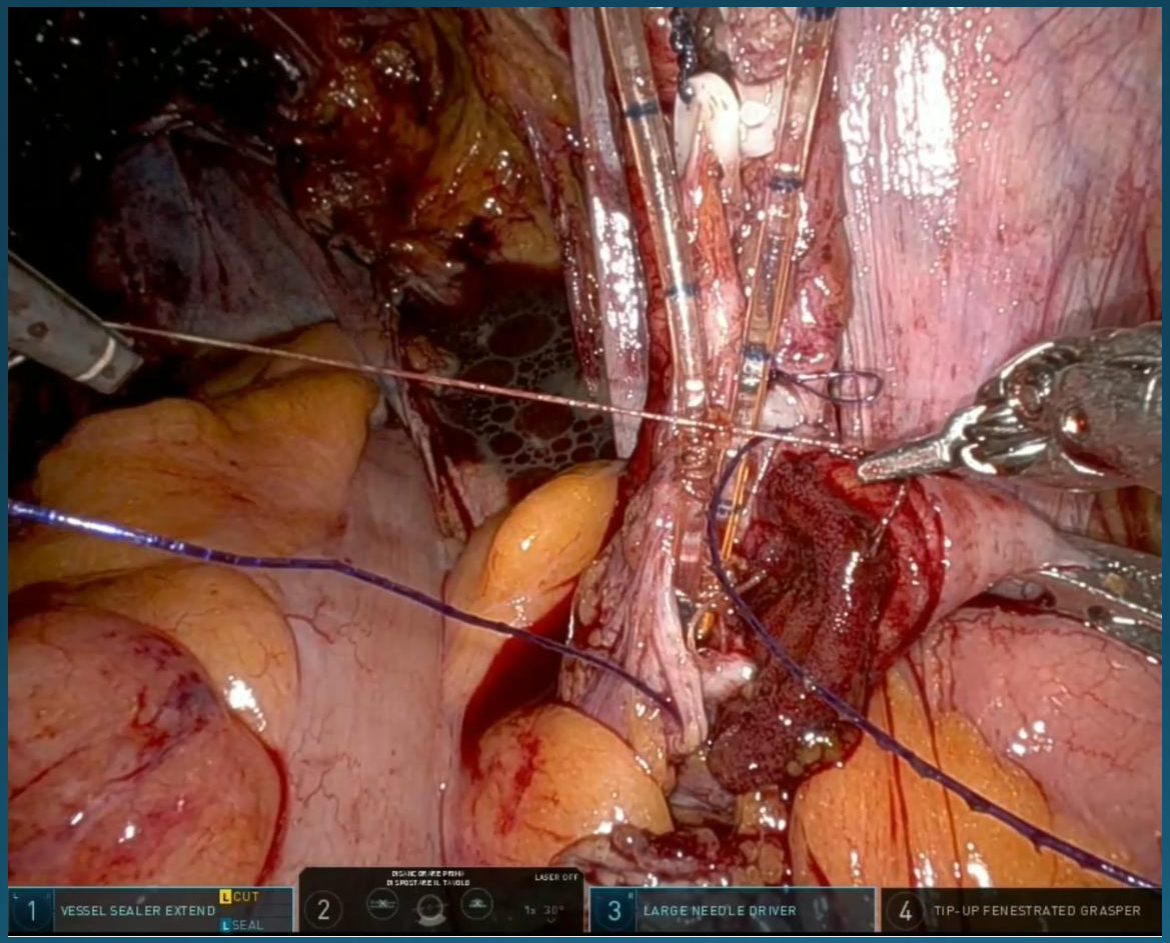

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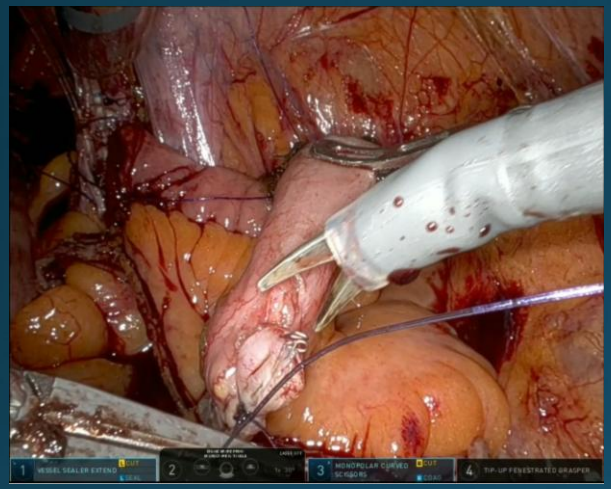

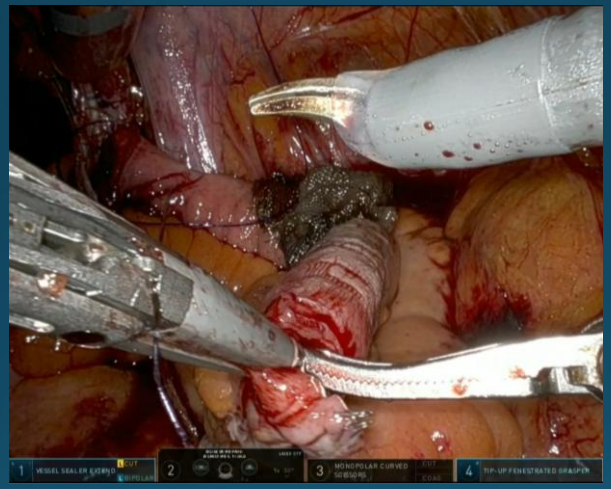

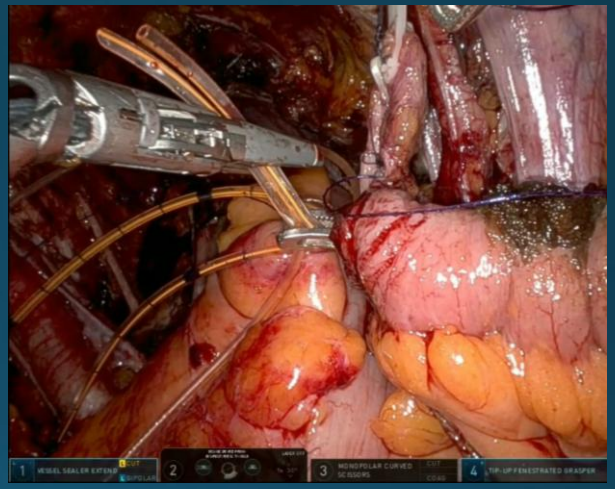

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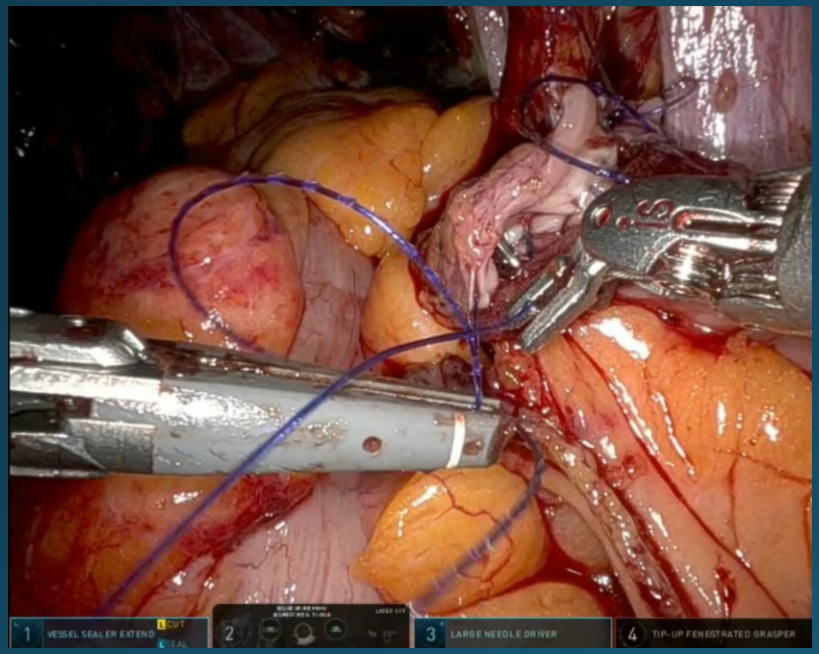

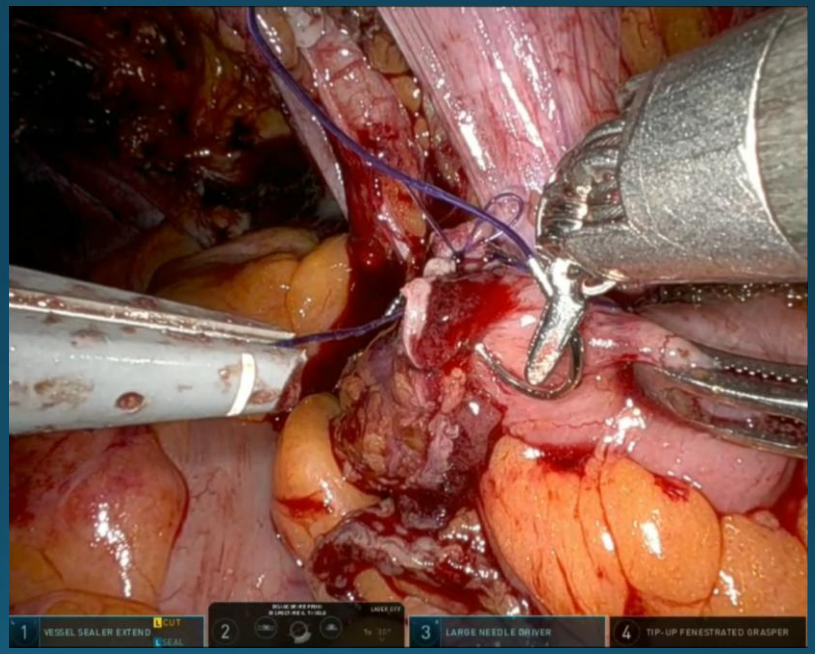

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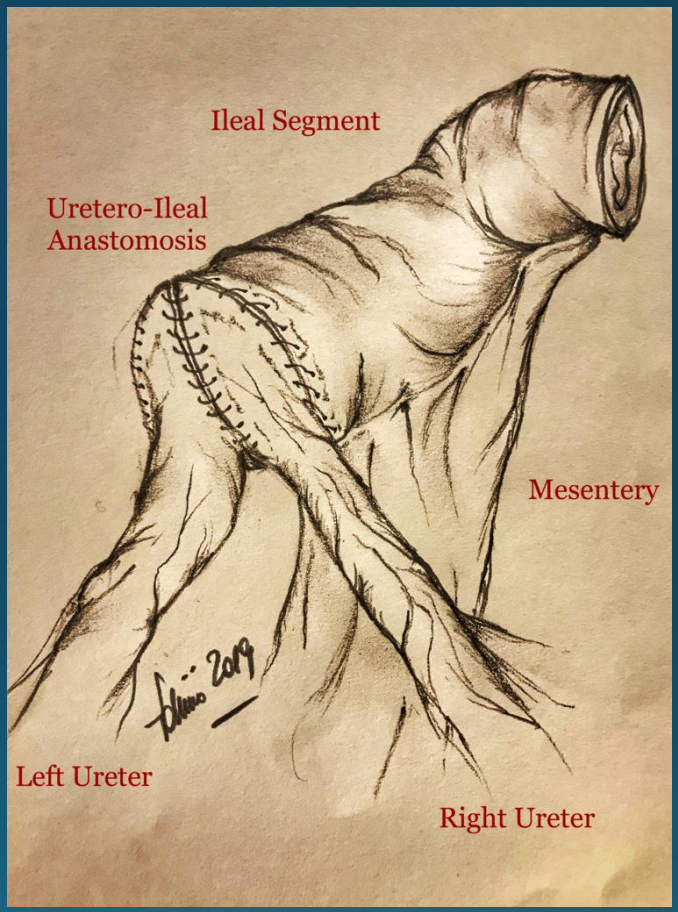

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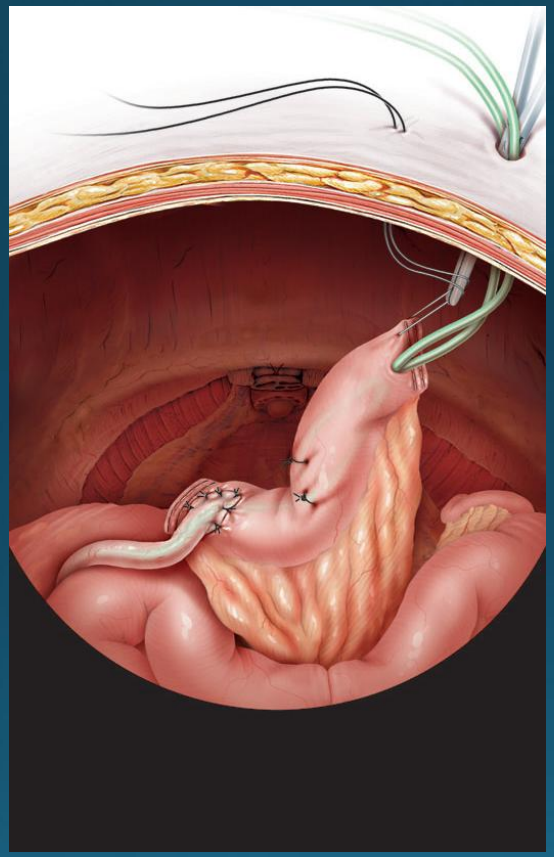

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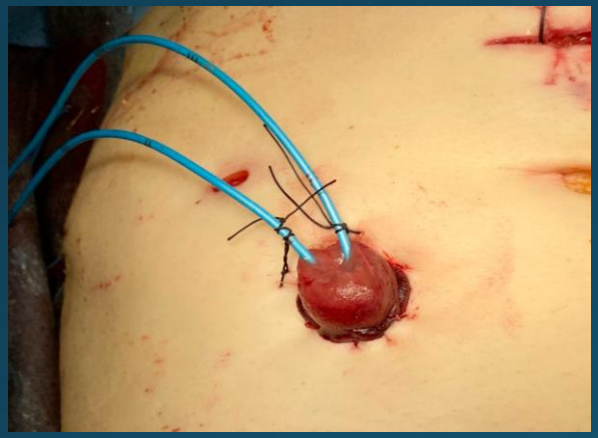
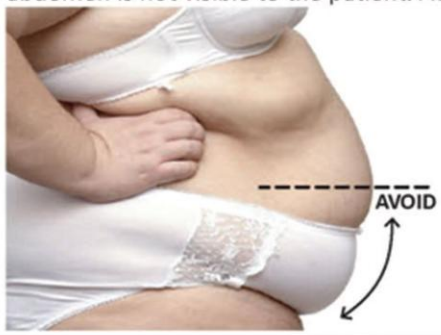


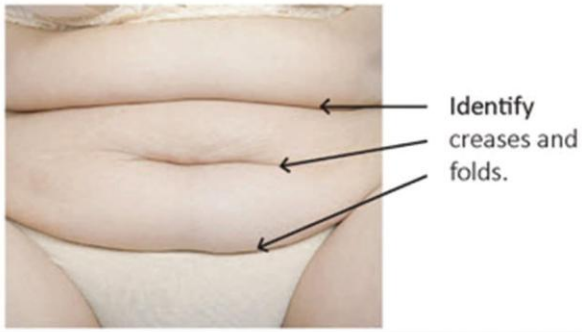
Step 1

Look at the profile of the patient. Notice where the abdomen curves back under toward the body. The underside of the abdomen is not visible to the patient. Avoid this area.



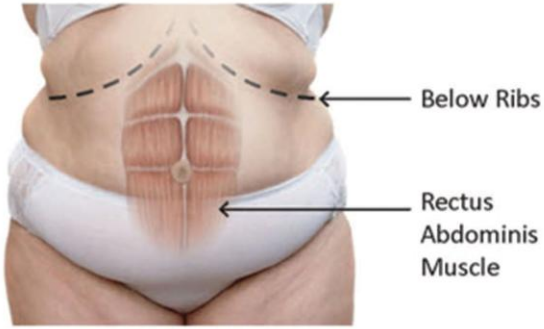
Step 2

While patient is seated, look for skin folds and creases. Note and avoid skin folds and creases.



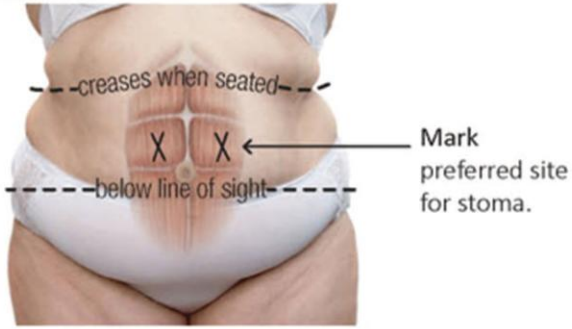
Step 3

Identify and target the rectus abdominis muscle below the ribs.



Step 4

Mark optimal stoma sites on the rectus abdominis, that are in patient's line of sight, while avoiding creases and skin folds.



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The epidemiology of obesity☆

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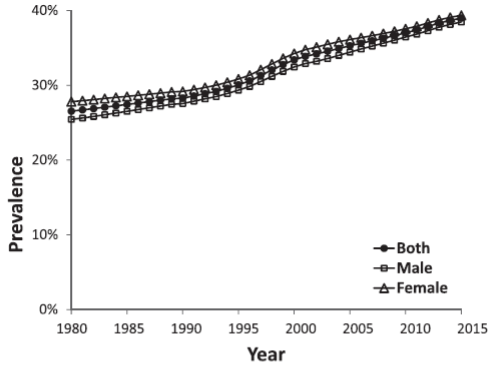
[b] Department of Physiology, Yong Loo Lin School of Medicine, National University of Singapore (NUS), Singapore
[c] Department of Nutrition, Exercise and Sports - Obesity Research, University of Copenhagen, Denmark



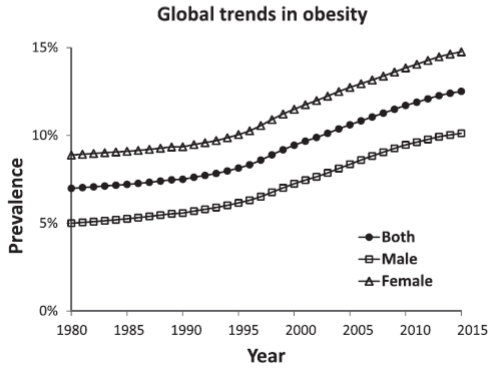


Fig. 2. Age-standardised global prevalence of overweight (top) and obesity (bottom) in men and women > 20 years old by year (ca. 1980–2015).

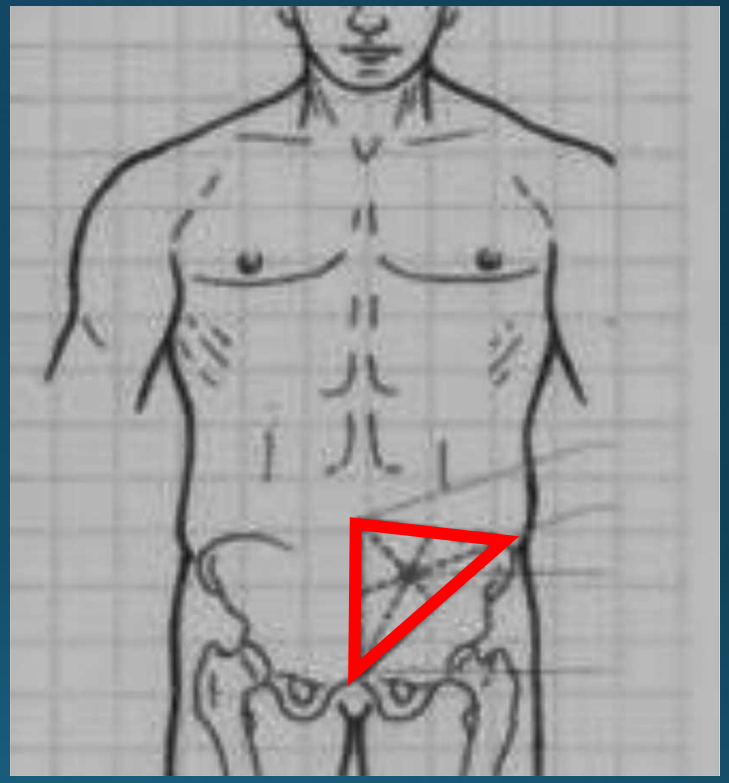
OSTOMY CARE

Italian Society of Surgery and Association of Stoma Care Nurses Joint Position Statement on Preoperative Stoma Siting

Gabriele Roveron ■ Giorgio De Toma ■ Maria Barbierato

Preoperative Stoma Siting

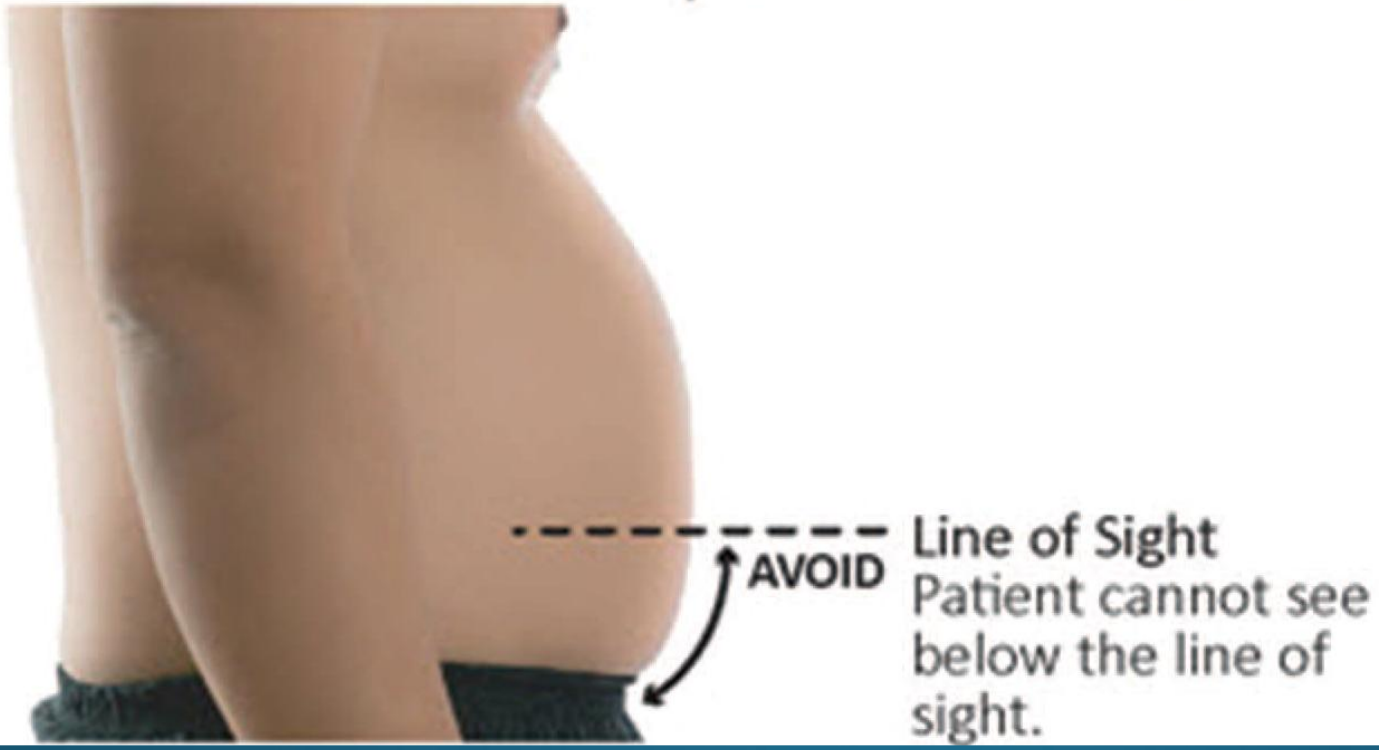
Preoperative siting is vital to the rehabilitation process of stoma patients. Associated counseling provides the opportunity to establish a relationship of trust with patients and their family and to (1) assess their knowledge about the reasons for surgery and stoma construction; (2) assess the patient's physical characteristics and psychological needs (which may affect the choice of stoma location); and (3) start an educational process aimed at providing autonomy in the management of the stoma.[4] After observing and assessing the shape of the abdomen and how it changes as posture changes, it is necessary to find a skin area that is reasonably large and flat (ie, with no scars, wounds, or skin folds) and away from anatomical structures such as bone saliences, navel and *linea alba*, which enables (1) the application of an appliance for the functional collection of effluents and the prevention of sudden and repeated detachments of the pouching device that could impair skin integrity and, above all, the patient's social life and self-esteem; (2) prevention of stoma complications such as peristomal hernia, retraction, prolapse, and peristomal skin lesions; and (3) rapid recovery of patient autonomy and self-esteem.



Ostomy Triangle

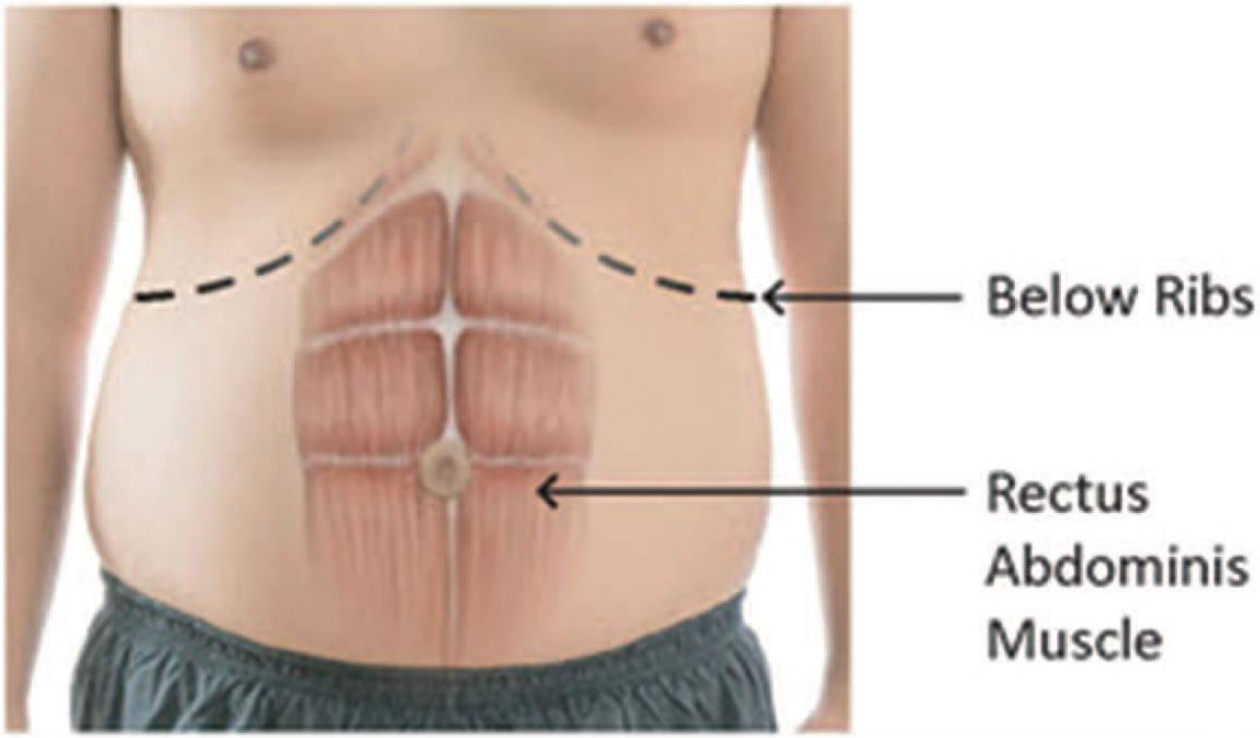
Step 1

Look at the profile of the patient. Notice where the abdomen curves back under toward the body. The underside of the abdomen is not visible to the patient. Avoid this area.



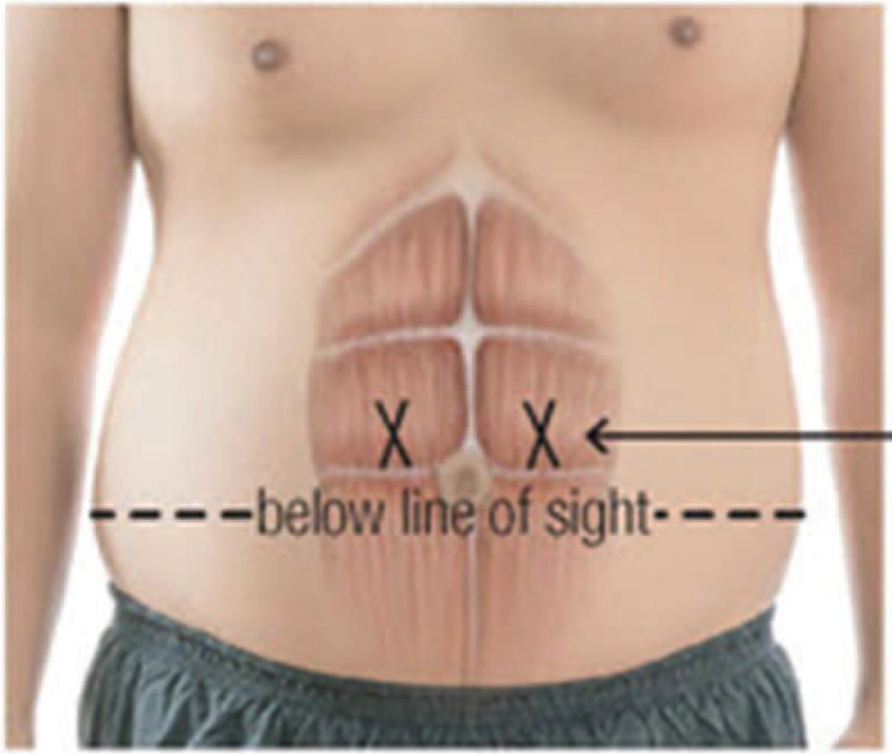
Step 2

Identify and target the rectus abdominis muscle below the ribs.



Step 3

Mark optimal stoma sites on the rectus abdominis muscle, that are in patient's line of sight, while avoiding creases and skin folds.



Peristomal body profile assessment tool

Define your patient's peristomal body profile to identify an appropriate ostomy solution

Patient name | Date | Nurse name

1	**The form of the area around the stoma** The form may change when sitting, lying down or moving.		**Regular**	The area is more or less level with the abdomen, although the skin surface may be uneven
			Inward	Sinks into the abdomen creating a hollow
			Outward	Rises from the abdomen creating a peak

Regular

Inward

Outward

Complicanze stomie urinarie

Complicanze stomie urinarie

Complicanze stomie urinarie

OSTOMY CARE

WOCN Society and AUA Position Statement on Preoperative Stoma Site Marking for Patients Undergoing Urostomy Surgery

Ginger Salvadalena ■ Samantha Hendren ■ Linda McKenna ■ Roberta Muldoon ■ Debra Netsch ■ Ian Paquette ■ Joyce Pittman ■ Janet Ramundo ■ Gary Steinberg

Ostomy education and stoma site selection should be performed preoperatively for all patients when an ostomy is a possibility.[1] Multiple studies indicate that patients who have their stoma site marked preoperatively by a trained clinician have fewer ostomy-related complications.[2-7]

An appropriate stoma site may decrease ostomy-related complications such as leakage of the pouching system and peristomal dermatitis. It may also influence the predictability of a pouch's wear time, ability of the patient to adapt to the ostomy and become independent, and may even help control healthcare costs. Preoperatively marking the stoma site allows assessment of the patient's abdomen in multiple positions, which promotes selection of the optimal stoma site. In addition, this preoperative session promotes a patient-centered approach respecting the individuality, values, and information needs of the

Conclusioni

- L’aspetto cruciale è la scelta «condivisa» della posizione della stomia tra Urostomista, Urologo e Paziente nei casi più complessi
- Ridiscussione collegiale dei «fallimenti»
- Attenzione al profilo corporeo e alle interazioni urine-cute del Paziente