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Outcomes of Posterolateral Fascial Reconstruction in Robot-Assisted Retzius-Sparing Radical Prostatectomy and Technique Description

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Abstract

Background/objectives: Prostate cancer is the most common cancer in men over 60 years of age. The development of assisted robotic surgery has improved surgical performance across several variables in dynamic ways, introducing new reconstruction techniques. The present study aims to show differences between Retzius-sparing robotic-assisted prostatectomy vs. Retzius-sparing and posterolateral fascial reconstruction in patients diagnosed with localized prostate cancer. **Methods:** A retrospective study was performed in a 3-year time period by a single surgeon using the Da Vinci X platform. Two groups were assessed for the study, with and without posterolateral fascial reconstruction. Demographic data were analyzed with central tendency measures, and mean differences were calculated with the Mann–Whitney test and t-test, being significant if $p < 0.05$. **Results:** A total of 199 patients were included. The posterolateral reconstruction group had 81 patients, and outcomes saw similar performances to the non-reconstruction group. Urinary continence showed a positive trend of higher percentages in the first week after surgery but had similar results after one year, with no statistically significant differences. Oncologic results and sexual dysfunction showed no statistically significant differences between groups. **Conclusions:** Posterolateral reconstruction combined with Retzius-sparing radical prostatectomy demonstrated improved continence and was shown to be safe, without increasing overall complications such as bleeding.

Keywords: prostate cancer; radical prostatectomy; robotic surgery; Retzius-sparing posterolateral reconstruction; urinary incontinence

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1. Introduction

According to the International Agency for Research on Cancer (IARC), prostate cancer (PCa) had a worldwide incidence of around 1,400,000 cases in 2022, with Europe being the region with the highest incidence (473,011). Regarding the Latin America and Caribbean

region, data showed that, in 2022, incidence was at nearly 226,000 cases. The number of cases reported for Mexico was 26,565. The global PCa mortality reported by IARC for 2022 was almost 400,000 deaths, with 7358 in México [1].

As a public health concern, PCa management saw dynamic progress in several ways, including new gonadotropin-releasing hormone (GnRH) antagonist, chemotherapy, and surgery techniques like robot-assisted prostatectomy, which is nowadays widely used [2–7].

Despite optimal results in the international literature, robot-assisted surgery may still be associated with functional complications, although in lesser numbers when compared with laparoscopic or open surgery, especially details such as urinary continence and erectile function [8,9].

As minimally invasive surgery has progressed, surgical techniques have been in turn developed to the point that, along with the improved ergonomics of these innovations, they have facilitated surgical execution and improved the functional outcomes of surgery compared to the open approach [10] or even when compared with robot-assisted techniques [11]. However, evidence is still inconclusive.

In 2010, Galfano et al. developed the Retzius-sparing or posterior approach [12,13]. This approach has significantly improved outcomes regarding early and short-term urinary function and quality of life compared to the previous approach. Regarding oncological outcomes, the evidence is mixed, but despite being associated with a higher rate of positive surgical margins, the Retzius-sparing approach is not associated with a significant decrease in biochemical recurrence-free survival.

It should be clear that the technique has some limitations, including reduced surgical space, a lack of anatomical landmarks, and a theoretically prolonged learning curve [14,15].

The present research aims to describe differences in general outcome after Retzius-sparing robotic-assisted prostatectomy vs. Retzius-sparing plus posterolateral fascial reconstruction (PLFR).

2. Materials and Methods

A retrospective study was performed, including 199 patients with PCa diagnosis and managed with robot-assisted radical prostatectomy. All subjects were candidates for surgery based on the National Comprehensive Cancer Network (NCCN) Guidelines. The first 118 cases were managed with conventional Retzius-sparing robot-assisted radical prostatectomy. For the last 81 patients, a surgical modification was added.

Statistical analysis included proportions, crude numbers, and central tendency measures. Mean differences were calculated with Chi-square, Fisher's exact test, *t* test, and Mann–Whitney U test. Significant differences were considered if $p < 0.05$.

All the surgeries were performed with the Da Vinci Robotic X (Intuitive Surgical Operations, Inc., Sunnyvale, CA, USA) and statistical data was collected using Excel V16.7 (Microsoft Corporation, Redmond, WA, USA) and OpenEpi version 3.01 (Open-Source Epidemiologic Statistics for Public Health).

The present version of the study was reviewed and approved by the Ethics Committee of Hospital Real San Jose Valle Real. Due to its retrospective design and the use of routinely collected surgical data, ethical approval was granted after committee review. Patient confidentiality was maintained throughout the study.

Posterolateral Fascial Reconstruction Technique Description

After completion of the vesicourethral anastomosis, using the same V-Lok sutures that were used for the urethrovesical anastomosis and without cutting them, the reconstruction was continued by approximating the posterolateral fascia up to the site where

the neurovascular bundles are located, doing this maneuver bilaterally, and subsequently finalizing the procedure.

The posterior fascial layer, corresponding mainly to the remnant Denonvilliers' fascia and posterior periprostatic fascial tissue, was identified bilaterally. Using the remaining ends of the anastomotic suture, the posterior fascia was approximated toward the posterolateral pelvic fascia adjacent to the neurovascular bundle and levator ani plane on each side.

The reconstruction was performed bilaterally with careful, tension-free needle passes, avoiding excessive traction or compression over the neurovascular bundles. The aim of this maneuver was to restore posterior and posterolateral support to the vesicourethral anastomosis, stabilize the urethral stump and rhabdosphincter complex, and reduce anastomotic tension. Once both posterolateral fascial planes were approximated, the suture was secured, completing the reconstruction.

3. Results

A total of 199 patients were included in the study. The median age was 64 years (SD 7.3: 95% CI 63.21–65.26). The Body Mass Index mean was 27.4 (SD 2.8: 95% CI 27.0–27.8) and the prostate-specific antigen had a mean of 10.2 ng/mL (SD 7.9: 95% CI 8.9–11.2). The intermediate risk, according to the NCCN classification, with 107 patients, had the highest frequency. Demographic and NCCN risk characteristics are depicted in Tables 1 and 2.

Table 1. Baseline demographic characteristics and comorbidities of patients undergoing Retzius-sparing robot-assisted radical prostatectomy.

Variable	Smoking	Alcoholism	Diabetes Mellitus	Hypertension
N (%)	21 (11%)	31 (16%)	18 (9%)	66 (33%)

Table 2. Distribution of patients according to NCCN prostate cancer risk classification.

Variable (NCCN Risk)	Low Risk	Intermediate Risk	High Risk	Very High Risk
N (%)	47 (23.6%)	107 (53.7%)	43 (21.7%)	2 (1%)

Prostatic volume was measured preoperatively using enhanced magnetic resonance imaging (MRI). After surgery, the volume values were obtained from pathologist reports (PR). The mean volume based on MRI and measured in grams was 45.5 g (SD 22.3; 95% CI 42.3–48.6), and for PR, it was 43.9 g (SD 18.3; 95% CI 41.3–46.5). Regarding volume, the p value was <0.05.

For the Gleason score and the ISUP values pre- and post-surgery, non-parametric tests showed non-significant differences ($p > 0.05$). The mode for Gleason scores pre- and post-surgery was 7. Table 3 depicts intraoperative details. Regarding the data in the table, there were no differences between the variables for the two techniques.

Table 3. Intraoperative and perioperative characteristics of Retzius-sparing robot-assisted radical prostatectomy.

Variable	Mean (Range)
Surgical time	155 min (98–325)
Console time	101.50 min (50–241)
Estimated bleeding loss (EBL)	180 mL (100–1000)
Hospital length of stay in days (LOS)	3 days (2–4)

According to the surgical technique, the non-PLFR group comprised 118 patients, whereas the PLFR group included 81 patients. No significant differences were reported

about age ($p > 0.05$), and regarding prostate volume, no difference was reported ($p > 0.05$). ISUP mode was 3 for the non-PLFR group and 2 for the PLFR group, respectively. The Foley catheter length in group one had a mean of 7.68 days (SD 1.51) versus 7.25 days (SD 0.84), with a p value <0.05. No complications were presented during surgery or after patients were discharged. No one needed blood transfusion and all patients were classified as Clavien-Dindo Grade I complications. No patient required radiological intervention, surgical reintervention or intensive care management.

Continence measurement was done at four instances: at one week, and after three, six, and twelve months of surgery. If patient showed continence at the first measurement, this was considered immediate continence. The use of one or more pads in any measurement was considered incontinence. Frequency of positive margins was 17.58% (35/199), with 26 from non-PLFR group. Table 4 depicts details and percentages of continence between groups over time after surgery, positive margins, and proportions of biochemical recurrence. Biochemical recurrence was defined as a sustained PSA level above 0.2 ng/mL during the first 12 to 24 months after surgery. Follow-up was performed at three, six, twelve, and eighteen months post-surgery. A total of 26 patients in both groups experienced biochemical recurrence during follow-up and were treated with radiotherapy.

Table 4. Comparison of urinary continence recovery, positive surgical margins, and biochemical recurrence between PLFR and non-PLFR groups.

Variable (n) p Value	Immediate Continence $p < 0.05$	3 Months $p > 0.05$	6 Months $p > 0.05$	1 Year $p > 0.05$	Positive Surgical Margins $p = 0.047$	Biochemical Recurrence $p > 0.05$
Non–PLFR (118)	94 (79.7%)	106 (89.8%)	111 (94.1%)	113 (95.8%)	26 (22%)	18 (15.3%)
PLFR (81)	70 (86.4%)	75 (92.6%)	77 (95.1%)	78 (96.3%)	9 (11.1%)	8 (9.9%)

PLFR: Posterolateral fascial reconstruction.

As can be seen, the PLFR group shows better results regarding continence at the four measured times and superior performance in biochemical recurrence. Statistical analysis with Chi square and Fisher's exact test showed no significant difference ($p > 0.05$) but only at the 3-month assessment. The p-value with respect to positive margins is marginal, although it can be cautiously assumed that there is a trend towards a lower frequency of positive margins with the PLRF.

Erectile function was measured using the Sexual Health Inventory for Men (SHIM) in both groups before and after surgery during follow-up, and a threshold of 17 was used, as many other studies have used. In the non-PLFR, the percentage of erectile dysfunction (SHIM < 17), before and after surgery, increased from 34 to 53% (from 41 patients to 63 patients). The final erectile function assessment was after one year of surgery. The PLFR group had similar results, before and after surgery, increasing the percentage of erectile dysfunction after surgery from 23% to 46% (from 19 patients before surgery with SHIM < 17 to 38 patients after surgery). This information is depicted in Table 5.

Table 5. Comparison of erectile function before and after surgery between PLFR and non-PLFR groups after one year of surgery.

Variable (n)	Pre-Surgery (SHIM < 17)	Post-Surgery (SHIM < 17)
Non-PLFR (118)	41 (34%)	63 (53%)
PLFR (81)	19 (23%)	38 (46%)

4. Discussion

Retzius-sparing robot-assisted radical prostatectomy (RS-RARP) has gained wide acceptance due to its reproducible advantage in early urinary continence recovery when compared with the standard anterior approach, as consistently demonstrated across randomized trials, prospective studies, and meta-analyses [4–6,9–11,14,15]. The preservation of anterior support structures, including the puboprostatic ligaments, endopelvic fascia, and *Santorini* plexus, provides a sound anatomical explanation for this benefit [12,13]. Nevertheless, despite these advantages, postoperative urinary incontinence remains a relevant clinical issue, indicating that further refinements within the RS-RARP framework may still be beneficial.

The primary endpoint of the study was postoperative urinary continence recovery, assessed at predefined follow-up interval after surgery and compared between patients undergoing RS-RARP with or without posterolateral fascial reconstruction. Secondary endpoints included erectile function recovery, positive surgical margin rated and biochemical recurrence.

In the present study, the addition of posterolateral fascial reconstruction (PLFR) to RS-RARP was associated with a trend of higher continence rates at all evaluated postoperative time points, including immediate continence and continence at 3 months, 6 months, and 12 months, when compared with RS-RARP alone. Although these differences did not reach statistical significance, the direction and persistence of the effect over time are clinically meaningful and suggest a potential additive benefit of PLFR beyond the Retzius-sparing approach itself.

Early urinary continence is one of the most relevant functional outcomes following radical prostatectomy, particularly during the first postoperative months, when quality of life is most affected [9–11,15]. While several high-quality studies have shown that RS-RARP accelerates early continence recovery compared with standard RARP, long-term continence rates tend to converge regardless of surgical approach [4–6,11]. In this context, the present findings suggest that PLFR may further optimize early and intermediate continence recovery within RS-RARP, without altering the expected favorable long-term outcomes.

The anatomical rationale for PLFR is supported by prior evidence demonstrating that posterior and posterolateral fascial reconstructions improve early continence by enhancing urethrovesical support, stabilizing the rhabdosphincter complex, and reducing tension at the anastomosis [16–19]. Notably, the RS-RARP learning curve literature suggests that continence outcomes can remain robust across different experience levels and institutional volumes when technique and key steps are standardized [20].

Importantly, the observed improvement in continence with PLFR was achieved without introducing measurable negative effects on other perioperative or oncological outcomes. Although concerns have been raised regarding oncological safety in RS-RARP—particularly positive surgical margins—contemporary comparative data generally support oncological non-inferiority when appropriately selected and executed [4–6,11,14,15]. In the study cohort, positive surgical margins were numerically lower in the PLFR group, and biochemical recurrence was also less frequent, although neither difference was statistically significant. These trends should be interpreted cautiously, but they are directionally aligned with modern comparative series showing similar cancer control between RS-RARP and conventional RARP approaches when balanced cohorts are examined [21].

Regarding erectile function, postoperative erectile dysfunction increased in both groups, a finding that aligns with the established literature on radical prostatectomy, regardless of surgical approach [5,6,18,19]. Importantly, the PLFR group did not demonstrate worse erectile outcomes than the non-PLFR group. This is clinically relevant, as any

additional reconstructive maneuver raises theoretical concerns regarding potential traction or compression of the neurovascular bundles.

Erectile function recovery after prostatectomy is multifactorial and depends on baseline erectile status, nerve-sparing technique, age, and tumor characteristics [5,6,18]. In RS-RARP, functional outcomes have been examined using both surgeon-reported and patient-reported measures; such evidence highlights that continence gains do not necessarily translate into parallel improvements in sexual function, and that postoperative sexual dysfunction may persist despite optimized anatomical preservation [15,20]. In the present study, PLFR was not associated with a clear improvement in erectile outcomes; however, the absence of deterioration supports the concept that PLFR is functionally safe with respect to neurovascular integrity. This is particularly relevant given contemporary data emphasizing the need for more nuanced continence definitions and patient-reported evaluation, showing that "pad-free" recovery can coexist with residual leakage or symptoms when measured by validated instruments [22]. A similar principle applies to sexual function assessment: categorical thresholds can mask clinically meaningful gradations, and prospective use of validated patient-reported outcome measures for sexual function may better define whether subtle differences exist between RS-RARP variants.

Other robot-assisted techniques have been published with good results; for example, Paladini et al. reported blood loss of 115 mL (mean) and 14 minor grade complications in a cohort of 108 high-risk patients. They concluded that robot-assisted minimally invasive surgery is safe with a minimal complication rate [23].

Regarding urinary continence, Doningerz-Argomedo et al. analyzed a cohort of 1943 patients after radical prostatectomy. A total of 42 were managed with robot-assisted radical prostatectomy and the others with laparoscopic approach. Robot-assisted radical prostatectomy showed better results regarding probability of continence recovery (HR 1.47; 95% CI 1.28–1.70; $p < 0.01$). After one year, continence rates ranged from 69% to 88% after the robotic approach and from 58% to 76% after laparoscopic management [24].

Taken together, these results support the interpretation that PLFR represents a functionally favorable adjunct to RS-RARP, primarily enhancing urinary continence recovery while maintaining erectile and oncological outcomes comparable to RS-RARP alone. The fact that continence advantages were observed consistently across all follow-up intervals, even in the absence of statistical significance, suggests that larger or randomized studies may be required to fully elucidate the magnitude of this effect.

Several limitations must be acknowledged. The retrospective design and lack of randomization limit causal inference, and continence assessment based on proportions rather than validated patient-reported outcome measures may underestimate subtle differences in urinary function. Additionally, the study was not powered to detect small differences in erectile function or oncological endpoints. Nevertheless, the internal consistency of the findings and their concordance with anatomical and functional principles strengthen the validity of the observed trends.

Another important limitation of the present research is the non-randomized sequential design. The first 118 patients underwent RS-RARP alone, whereas the subsequent 81 underwent RS-RARP with posterolateral fascial reconstruction. The observed differences between groups may have been influenced not only by the reconstruction technique itself but also by temporal factors, including increased surgeon experience, refinement of surgical skills, perioperative improvements, and patient selection over time. Although all procedures were performed by a single experienced surgeon, a learning-curve effect cannot be completely excluded. Consequently, the functional benefits observed with posterolateral fascial reconstruction should be interpreted with caution and confirmed in prospective studies.

5. Conclusions

In conclusion, the addition of posterolateral fascial reconstruction to Retzius-sparing robot-assisted radical prostatectomy was associated with favorable functional outcomes, although further refinement of the technique and additional high-quality studies are needed to optimize and confirm these results. However, it is associated with a consistent trend toward improved urinary continence recovery at all evaluated postoperative time points, without compromising erectile function or oncological safety. While statistical significance was not demonstrated, the directionality and persistence of the observed effects support the potential clinical value of PLFR as a refinement of the RS-RARP technique. Future prospective and randomized studies incorporating standardized patient-reported functional outcome measures are warranted to confirm these findings and better define the role of PLFR in optimizing functional recovery after minimally invasive prostate cancer surgery.

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Informed Consent Statement: Informed consent was obtained from all subjects involved in the study prior to surgery.

Data Availability Statement: The data that support the findings of this study are available from the first and the corresponding author (Gastón Ochoa-León and Erick Sierra-Díaz); however, restrictions apply to the availability of these data, which were used under license for the current study, and as such, they are not publicly available. Data are, however, available from the authors upon reasonable request.

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Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

IARC	Agency for Research on Cancer
GnRH	Gonadotropin-releasing hormone
PLFR	Posterolateral fascial reconstruction
SHIM	Sexual Health Inventory for Men
RS-RARP	Retzius-sparing robot-assisted radical prostatectomy

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