

PACE - Prostatectomy Assessment and Competency Evaluation

DOMAINS*	1	2	3	4	5
Bladder Drop					
Identify and Dissect away from Umbilical Ligaments & Pubic Bone	<ul style="list-style-type: none">• Injury to the Bladder/Pelvic Side Wall and/or adjacent Obturator Vessels/Nerve		<ul style="list-style-type: none">• Entry into Peri-vesical Fat; or Bleeding Obscuring the Operative Field; or Inadequate Lateral Dissection and/or Curtain of Tissue left anteriorly		<ul style="list-style-type: none">• Clean Dissection that respects all Surgical Planes with Minimal /no Bleeding and Preservation of Accessory Vessels if present
Preparation of the Prostate					
Defatting Prostate with Dorsal Venous Complex (DVC) Preservation	<ul style="list-style-type: none">• DVC and/or Periprostatic Bleeding• Inadequate Defatting/Injury of Anterior Prostate-Vesical Junction• Untimely and/or Inadvertent Opening of Endopelvic Fascia• Bladder not released from Pelvic Side Wall		<ul style="list-style-type: none">• Suboptimal Hemostasis• Inadequate Anterior Prostate-Vesical Exposure with Acceptable Bladder release from Pelvic Side Wall		<ul style="list-style-type: none">• Adequate Prostate-Vesical Exposure with Minimal/no Bleeding• Appropriate and Planned Opening of Endopelvic Fascia• Bladder released from Pelvic Side Wall
Bladder Neck Dissection					
Dissection of the Bladder Neck from the Prostate	<ul style="list-style-type: none">• Wrong Plane with Subsequent Entry into the Prostate and/or weak (thin) Posterior Bladder Neck• Injury or close proximity to the Ureteric Orifices or Trigone• Leaves Prostate Tissue on the Bladder		<ul style="list-style-type: none">• Disproportionate Bladder Neck• Deviates from Prostate-Vesical Junction but returns to the Correct Plane		<ul style="list-style-type: none">• Identifies and divides the Natural Groove which delineates the Prostate-Vesical Junction• Proportionate Bladder Neck with adequate thickness and without entry into the Prostate
Dissection of the Seminal vesicles (SV) and Posterior Anatomical Plane					
Dissection of Seminal Vesicles (SV)	<ul style="list-style-type: none">• Unintentional Retained Portion of SV• Excessive Use of Cautery• Uncontrolled bleeding from vessels around SV		<ul style="list-style-type: none">• Complete Removal of the SV despite Inadvertant Entry• Vessels Torn with subsequent Control of Bleeding		<ul style="list-style-type: none">• Complete Atraumatic Removal of SV with Minimal Traction• Appropriate Use of Cautery
Development of Posterior Anatomical Plane	<ul style="list-style-type: none">• Entry into the Base of the Prostate• Inappropriate use of Cautery• Rectal injury		<ul style="list-style-type: none">• Initial Entry into Suboptimal Plane close to the Prostate or Rectum with subsequent Correction of the Anatomical Plane		<ul style="list-style-type: none">• Anatomical Plane created down to the Posterior Urethra with Minimal Bleeding and Tearing of Tissue
Preservation of Neurovascular Bundle (NVB)					
Neurovascular Bundle (NVB) Preservation	<ul style="list-style-type: none">• Entry into the Prostate• Inappropriate Use of Cautery• Damage to the Main Trunk of the NVB		<ul style="list-style-type: none">• Excessive Traction on/around NVB• Poor Set up/Visualization of Operative Field• Excessive Bleeding• Inadequate Release of NVB at/ adjacent to Apex of the Prostate		<ul style="list-style-type: none">• Balanced Hemostasis with Proper Dissection up to and beyond the Apex of Prostate and Urethra• Appropriate Use of Cautery
Apical Dissection					
Apical Dissection	<ul style="list-style-type: none">• Entry into the Apex of Prostate with Remnants of Prostate Tissue left on the Urethra• Untimely Entry into the DVC• Excessive Traction and injury/shortening of the Urethra• Injury to the Lateral Apical NVB		<ul style="list-style-type: none">• Unable to clearly separate Prostatic Apex from the Urethra• Inadequate Closure of the Dorsal Venous Sinuses with Persistent Bleeding• Uneven edges of the urethral incision		<ul style="list-style-type: none">• Complete Control of Dorsal Venous Sinuses with Adequate Urethral Length and Preservation of the NVB
Urethro-Vesical anastomosis					
Needle Entry	<ul style="list-style-type: none">• Needle Tip usually (>75%) enters Non-Perpendicular		<ul style="list-style-type: none">• Needle Tip usually enters half the time Non-Perpendicular		<ul style="list-style-type: none">• Needle Tip usually (>90%) enters Perpendicular
Needle Driving & Tissue Trauma	<ul style="list-style-type: none">• Wrist Rotation seen <25% times with Tissue Trauma		<ul style="list-style-type: none">• Wrist Rotation seen <50% times with Minimal Tissue Trauma		<ul style="list-style-type: none">• Wrist Rotation almost always (>90%) seen with no Tissue Trauma
Urethro-Vesical Approximation	<ul style="list-style-type: none">• Poor Approximation of Posterior Plate• Significant Leakage after Irrigation requiring Re-anastomosis		<ul style="list-style-type: none">• <50% of Circumferential Approximation• Minor Leakage after Irrigation requiring Repair		<ul style="list-style-type: none">• Well Approximated• Water Tight after Irrigation

* The presence of any single or multiple criteria within each anchor qualifies for that score.