

Testicular Prostheses for Testis Cancer Survivors: Patient Perspectives and Predictors of Long-Term Satisfaction

Ofer Yossepowitch,* Dina Aviv, Liat Wainchwaig and Jack Baniel

From the Institute of Urology, Rabin Medical Center, Beilinson Campus, Petach Tikva, and Sackler Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel

Purpose: We assessed the perspectives of patients with testicular cancer on the placement of a prosthesis at orchiectomy and identified predictors of long-term satisfaction.

Materials and Methods: Consecutive patients who underwent radical orchiectomy for testicular cancer in 1995 to 2009 were asked to complete a telephone questionnaire covering background demographics, subjective assessment of implant characteristics, impact of the prosthesis on daily and sexual activities, and overall satisfaction with outcome.

Results: A total of 98 patients completed the interview, of whom 86 (87%) received a prosthesis. Median interval from surgery to interview was 6 years and most men were married or engaged in a steady relationship. The majority found the prosthesis to be of appropriate weight and size. The main complaints were firm consistency (70%) and high scrotal position (39%), both of which were significantly associated with lesser patient satisfaction ($p = 0.03$) and regret of the decision to accept an implant ($p = 0.02$). Approximately 15% of patients indicated the prosthesis interfered with physical exercise or sexual activity. Younger age at surgery was associated with a greater likelihood of accepting a prosthesis but not with long-term satisfaction. Overall the outcome was rated good to excellent in 77% of cases.

Conclusions: Patients with testicular cancer scheduled to undergo orchiectomy should be offered a testicular prosthesis, and reassured that complications are few and that expected long-term satisfaction is fair. Optimizing the texture of the implant and its position in the scrotum may improve outcome. However, patients should be counseled about possible adverse implications in terms of physical exercise or sexual activity.

Key Words: testicular neoplasms, prostheses and implants, decision making, patient satisfaction

THE management of testicular germ cell tumors is considered a benchmark in urological oncology, where the proper integration of surgery, chemotherapy and radiation therapy renders most patients free of disease. With established high cure rates, efforts are now being directed toward reducing treatment related toxicity without compromising long-term on-

colgic efficacy. Given the young age and protracted life expectancy of affected patients, urologists are required to carefully consider all physical, psychological and social aspects of the disease and its treatment. In this context, to improve patient body image and self-esteem, efforts are routinely made to restore the normal appearance of the scrotum with a tes-

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* Correspondence: Urologic Oncology Service, Institute of Urology, Rabin Medical Center, Beilinson Campus, Petach Tikva 49100, Israel (telephone: 972-3-937-6553; FAX: 972-3-937-6569; e-mail: oferyoss@netvision.net.il).

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ticular prosthesis.¹ Although several studies have highlighted the imperative to offer an implant to all men who lost (or are about to lose) a testicle,²⁻⁷ the long-term outcome of the procedure in survivors of testicular cancer and possible reasons for disappointment or regret remain poorly defined. In this study we assessed the perspectives of patients diagnosed with testicular cancer on the placement of a testicular prosthesis and identified predictors of long-term patient satisfaction.

METHODS

The study protocol was approved by the institutional review board. A total of 148 consecutive men who underwent radical orchiectomy for testicular cancer in 1995 to 2009 at a tertiary university affiliated medical center were asked to participate in a telephone interview by 2 of the study authors. Of these patients 98 consented. Participants were informed about the specific aims of the study, and completed a 4-part predesigned questionnaire on demographics and disease status (cancer), subjective implant characteristics (dimensions, texture and scrotal position), impact of the prosthesis on daily/sexual activities and overall patient satisfaction. In the last part the patients were encouraged to express feelings in their own words in an open and honest manner. To ensure that the study cohort was homogenous, we excluded adolescents and men who lost a testicle early during childhood or from noncancer causes.

Surgical Technique

The prosthesis, bathed in antibiotic solution, was delivered into the scrotum via an inguinal incision immediately following removal of the tumor bearing testicle. During the early study years the prosthesis was secured to the most dependant portion of the scrotum with a nonabsorbable suture placed through its designated suture loop, and the scrotal skin was inspected for evidence of suture perforation or dimpling. However, on the basis of publications in the medical literature^{5,6} and the large number of patient complaints regarding the implant's high scrotal position, in 2005 we abandoned the practice of transfixation so that the prosthesis could move naturally in the scrotum. At that time we also switched to a softer implant model in response to patient complaints of its firm consistency. The size of the implant was determined by the surgical team during surgery. There was no preplanning and the patients were not involved in this decision. All prostheses were placed at the initial surgery via the inguinal approach and none was inserted subsequent to orchiectomy as a separate procedure.

Statistical Analysis

For statistical analysis of the questionnaire responses we used Stata® version 10.1. Basic descriptive statistics were calculated for categorical and continuous variables. The chi-square test was applied to compare satisfaction and assessment of the implant scrotal position before and after modifying the surgical technique (2005). To test associations between patient demographics and overall satisfaction, we stratified satisfaction into 5 distinct ordinal cat-

egories of excellent, good, fair, poor and very poor. Nonparametric analyses were used to assess trends and associations across these ordered categories. The *nptrend* command in Stata was used for continuous variables (age at orchiectomy, age at interview and interval in years from surgery to interview) and the Mann-Whitney test was applied for dichotomous variables (marital status at orchiectomy and interview as single/married, and implant characteristics as appropriate/inappropriate). We also tested associations among the various parameters and patient acceptance or regret of the original decision. All statistical tests were 2-sided and $p < 0.05$ was considered significant.

RESULTS

Table 1 depicts the demographic characteristics of the 98 study patients. The median interval from surgery to study interview was 6 years. Most men were married or engaged in a steady relationship at the time of orchiectomy and at the interview. The majority (96%) were cured of cancer.

Of the 98 men 86 (87%) received a testicular prosthesis at surgery, including 2 given bilateral implants. In 93% of cases the prosthesis had been in place for at least 1 year at the time of the interview. The other 12 men (13%) refused a prosthesis, mostly because they did not believe the appearance of 2 testes in the scrotum was important or because of concern about potential adverse effects from a foreign body. None of the participants reported immediate postoperative complications (infection, pain or dehiscence and prosthesis extrusion).

The figure illustrates the patients' subjective evaluation of implant appearance and texture. Most found the prosthesis to be of appropriate size and weight. However, 70% of the patients thought the consistency was too firm and 39% thought the position in the scrotum was too high. These findings prompted us to modify the surgical technique in 2005 and substitute a softer implant. Of the 57 men who received a prosthesis before 2005 only 18 (32%) found the implant position in the scrotum to be

Table 1. Demographic characteristics of study participants

Median age at orchiectomy (IQR)	27 (22, 30)
Median age at interview (IQR)	33 (26, 37)
Median yrs from surgery to interview (IQR)	6 (4, 7)
No. marital status at orchiectomy (%):	
Single*	42 (43)
Married†	56 (57)
No. marital status at interview (%):	
Single*	31 (32)
Married†	67 (68)
No. disease status at interview (%):	
Cured	95 (96)
Alive with disease	3 (4)

* Including divorced.

† Or a partner in a steady relationship.

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