

Post-Prostatectomy Male Sling Revision and Early Results

James H. Masterson* and Eugene Y. Rhee^{†,‡}

From the Division of Urology, Department of Surgery, Naval Hospital Yokosuka, Yokosuka, Japan, and Department of Urologic Surgery, Southern California Permanente Medical Group, San Diego, California

Abstract

Introduction: Male slings are an accepted form of therapy in the incontinent man with a reported 55% to 80% success rate. Failed slings may be salvaged by performing a retensioning surgical sling revision procedure. The procedure is performed through a perineal incision that partially exposes the cicatrix containing the sling. Imbricating sutures are then placed and the patient is discharged home the same day without a catheter. Operative and postoperative details of this procedure are presented.

Methods: We retrospectively analyzed the records of the first 16 patients to undergo sling revision from June 2010 to March 2013. Patient age, pad count before and after initial sling placement, sling revision and followup time were investigated. Operative time, complications and blood loss were also analyzed.

Results: Median operative time was 37 minutes with a median blood loss of 5 ml. There were no surgical complications. The median daily pad count decreased from 4 to 1.3 ($p = 0.002$). After the procedure 63% of men improved and 44% were pad-free.

Conclusions: Sling revision appears promising as an easily reproducible salvage technique for failed slings.

Key Words: urethra; urinary incontinence, stress; male slings; urinary sphincter, artificial; surgical revision

Abbreviations and Acronyms

AUS = artificial urinary sphincter

PPD = pads per day

RLPP = retrograde leak point pressure

Men with persistent stress incontinence after prostatectomy are offered an AUS or a male sling. The male sling is a less complicated procedure with a lower failure rate than the

AUS but it is not recommended for severe incontinence.¹⁻³ There is no general consensus on how to treat continued or recurrent incontinence after placement of a male sling.

Submitted for publication November 23, 2014.

The corresponding author certifies that, when applicable, a statement(s) has been included in the manuscript documenting institutional review board, ethics committee or ethical review board study approval; principles of Helsinki Declaration were followed in lieu of formal ethics committee approval; institutional animal care and use committee approval; all human subjects provided written informed consent with guarantees of confidentiality; IRB approved protocol number; animal approved project number.

The views expressed in this article are those of the author(s) and do not reflect the official policy or position of the Department of the Navy, Department of Defense, or the United States Government.

* No direct or indirect commercial incentive associated with publishing this article.

[†] Correspondence: Department of Urologic Surgery, Southern California Permanente Medical Group, 4650 Palm Ave., 3rd Floor, San Diego, California 92154 (telephone: +81-46-816-7855; e-mail address: eugenerhee@mac.com).

[‡] Financial interest and/or other relationship with Coloplast and American Medical Systems.

Placement of a second male sling or an AUS is a viable option.^{1,2,4} Rhee described a straightforward and technically easy method to retension a failed quadratic sling.⁵ The quadratic sling is a 4-armed large pore, knitted monofilament polypropylene mesh that provides proximal urethral relocation via a transobturator component and perineal urethral compression via a superior prepubic component.⁶

We describe the results of our initial cohort using the sling salvage technique.

Methods

We retrospectively reviewed the records of all patients who underwent sling revision performed by a single surgeon from June 1, 2010 to March 1, 2013. Only men with a quadratic sling were included in analysis. Men with a quadratic sling in addition to an alternative sling were also included. Not all initial slings were placed by one of us.

For the procedure the patient was prepared and draped in the low dorsal lithotomy position. Anesthesia was general or spinal and all patients received prophylactic antibiotics. A 14Fr urethral catheter was placed. Dissection through a midline perineal incision was carried down to the previous sling, which was ingrown with fibroblastic tissue forming a cicatrix. The distal edge of the mesh was exposed for a lateral distance of 4 to 5 cm.

We then determined RLPP in a previously described manner.^{7,8} The urethral catheter was repositioned to the distal phallus and the balloon was gently inflated in the fossa navicularis with 3 ml sterile water. An intravenous bag with a drip chamber was suspended 60 cm above the level of the pubic ramus. While observing the drip chamber, zero Prolene® imbricating sutures were placed laterally through the mesh and tautened (fig. 1). When the drip chamber showed a slow or no drip, the sutures were tied from distal to proximal while carefully noting the slower dripping of the water chamber at 60 cm water pressure until this stopped. Figures 2 and 3 show proper placement of the sutures in the exposed mesh. It is important to note that the imbricating sutures were tied down completely from distal to proximal to ensure that the suture was strategically placed. This was determined according to intraoperative feedback on the success of the initial suture that was completely tied down. The catheter balloon was deflated and repositioned in the bladder to ensure patency.

The incisions were closed in at least 2 layers and the catheter was removed in the recovery ward. All patients were discharged home the same day. Success was defined as 0 PPD of leakage. PPD, operative details and complications were analyzed. Time to revision was also noted as well as the latest followup.

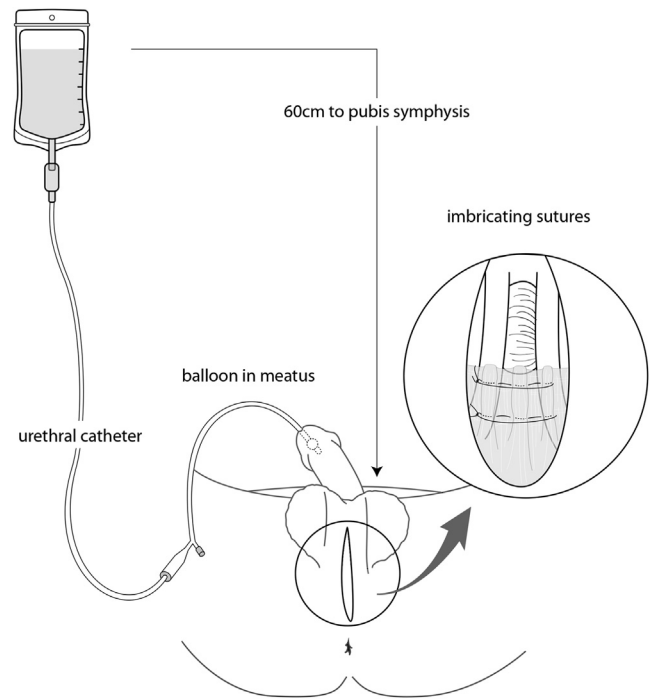


Figure 1. Intravenous bag is placed so that fluid level is 60 cm above pubic symphysis. Drip chamber is observed when tightening permanent imbricating sutures, which are placed through existing mesh with ingrown scar tissue and tightened from bottom to top.

All statistical analysis was performed with Stata®, version 12.0. Continuous data were analyzed by the Wilcoxon rank sum test with significance considered at 2-sided $p < 0.05$.

Results

We identified 16 patients who underwent the procedure, of whom 15 were used for pad count calculations. One patient was fully incontinent prior to sling revision and used a condom catheter. After the initial sling was placed he



Figure 2. Quadratic sling is shown superimposed over perineum in correct orientation.

Download English Version:

<https://daneshyari.com/en/article/4276964>

Download Persian Version:

<https://daneshyari.com/article/4276964>

[Daneshyari.com](https://daneshyari.com)