

Distal Corporal Anchoring Stitch: A Technique to Address Distal Corporal Crossovers and Impending Lateral Extrusions of a Penile Prosthesis



Gabriele Antonini, PhD, MD,¹ Gian Maria Busetto, PhD, MD,¹ Francesco Del Giudice, MD,¹ Matteo Ferro, PhD, MD,² Benjamin I. Chung, MD,³ Simon L. Conti, MD,³ Alfredo Suarez Sarmiento, MD,⁴ Arianna Pacchiarotti, PhD, MD,⁵ Ettore De Berardinis, MD,¹ and Paul E. Perito, MD⁴

ABSTRACT

Background: Unidentified distal crossovers, delayed distal crossovers, and impending lateral extrusion are complications of penile prosthesis implant insertion but are not as common as prosthesis infection or mechanical failure.

Aim: To evaluate results of a surgical technique, the distal corporal anchoring stitch, that addresses fixation of the penile prosthesis in patients with these complications.

Methods: A lateral sub-coronal incision is used on the side where the crossover or laterally extruding cylinder should be positioned. Dissection is carried through the Buck fascia, followed by a transverse incision of the tunica albuginea, where the distal aspect of the affected cylinder is delivered. A 4-0 PDS suture is threaded through the distal cylinder ring of the implant. A new, properly positioned intracorporal channel is created and the suture is passed through the distal end of the channel. Once the suture is through the glans and the cylinder is in the correct position, a small cruciate incision is made on the glans at the location of the anchor stitch. The suture is tied with the knot buried in the glans tissue.

Outcomes: Fifty-three patients underwent treatment of their distal penile implant crossover with a distal corporoplasty using this method and their anatomic and functional outcomes and overall satisfaction were evaluated.

Results: This technique ensured that the cylinder remained in the newly created, appropriately positioned channel. No patients developed infections, wound-healing defect, glandular hypoesthesia, anesthesia, or altered sensation or pain in the glans related to the suture and only two reported recurrence of a lateral herniation that did not require further treatment.

Clinical Implications: Distal fixation of the penile prosthesis is a useful surgical adjunct to treating patients with prosthetic lateral extrusions or crossovers that can be applied in almost all cases.

Strengths and Limitations: Considering these rare complications, our experience is based on a relatively large number of patients and showed a low incidence of complications and a high satisfaction rate. The main limitation of this study is the retrospective nature of the data and the series included patients from two high-volume surgeons that might not be generalizable to all practices.

Conclusion: The distal corporal anchoring stitch is safe and effective in securing distal fixation of the extruding inflatable penile prosthesis. **Antonini G, Busetto GM, Del Giudice F, et al. Distal Corporal Anchoring Stitch: A Technique to Address Distal Corporal Crossovers and Impending Lateral Extrusions of a Penile Prosthesis. J Sex Med 2017;14:767–773.**

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Key Words: Distal Corporal Crossover; Impending Lateral Extrusion; Penile Prosthesis

INTRODUCTION

Erectile dysfunction has an incidence ranging from 2% to 83% that varies with age and comorbidities and has an important

effect on male sexuality and quality of life that can the female partner's sexual life.¹ Inflatable penile prosthesis (IPP) implantation is a reliable treatment in almost all cases of medically

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¹Department of Urology, Sapienza University of Rome, Rome, Italy;

²Department of Urology, Milan European Oncology Institute (IEO), Milan, Italy;

³Department of Urology, Stanford University Medical Center, Stanford, CA, USA;

⁴Miami Urology Specialists, FL, USA;

⁵Department of Urology, Rome San Filippo Neri Hospital, Italy

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Table 1. Patient characteristics

Patients, N (%)	53 (100)
Age (y), median (range)	61.3 (44–71)
BMI (kg/m ²), median (range)	25.7 (21–29)
Hypertension, n (%)	22 (41.5)
Diabetes, n (%)	13 (24.5)
Active smokers, n (%)	18 (33.9)
Pathogenesis of ED, n (%)	
Multifactorial	33 (62.2)
Iatrogenic	20 (37.7)
IPP	0
Type of device implanted, n (%)	
AMS	23 (43.4)
Coloplast	30 (56.6)
Years from implant to surgical revision, median (range)	4.2 (1–9)
Site of corporal extrusion, n (%)	
Lateral extrusion	39 (73.5)
Unidentified distal crossovers	9 (16.9)
Delayed distal crossovers	5 (9.4)

BMI = body mass index; ED = erectile dysfunction; IPP = inflatable penile prosthesis.

refractory erectile dysfunction. As a demonstration of safety and effectiveness, recent data have reported satisfactory operation rates for primary implantation of 96% at 5 years and 60% at 15 years.²



Figure 1. Identification of impending extrusion or crossover. Figure 1 is available in color at www.jsm.jsexmed.org.



Figure 2. Longitudinal incision localization. Figure 2 is available in color at www.jsm.jsexmed.org.

After the first IPP implantation reported by Scott et al³ in 1973, many advances in surgical technique and device technology have increased patient safety and satisfaction.⁴ As expected, complications occur more commonly in patients with diabetes, spinal cord injury, and immunosuppression. Reported revision surgery for IPP implantation is more commonly required for cosmetic and erosion problems as opposed to mechanical failure.⁵ The most common device failure is fluid leak from the prosthesis, whereas supersonic transport deformity, cylinders aneurismal dilatation, cylinders crossover, and impending lateral extrusion are less common.⁶ It has been suggested that device replacement compared with repair leads to improved outcomes.^{5–7}

When dealing with crossovers and impending lateral extrusions, it is important to determine which cases have evidence of urethral or skin extrusions and which cases have frank erosion. These complications are not as common as PP infection or mechanical failure but are as well described. In almost all cases, surgical repair is required and can be carried out with or without prosthesis explantation. The most ventral and distal portions of the corpora cavernosa are the thinnest, which has been suggested as the cause of the extrusions that commonly occur in these areas.⁸ Crossovers and extrusions can be tested by placing a metal instruments such a Brooks dilator on the healthy corpora cavernosa and a second instrument on the contralateral corpora; this maneuver will accentuate the real anatomy and ensure an accurate evaluation of the damage.

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