

The Top 5 Surgical Things That I Wish I had Known Earlier in My Career: Lessons Learned From a Career of Prosthetic Urology



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Dr Brantley Scott pioneered the field of prosthetic urology in the early 1970s. He actually invented the 2 devices, inflatable penile prosthesis (IPP) and artificial urinary sphincter (AUS), that are relatively unchanged in design almost 50 years later. I finished my urology residency in 1973; joined my father in practice in Fort Smith, AR; and attended Scott's second instructional course in 1974. It was to be a love affair with prosthetic urology, a tiny specialty niche of urology, for the rest of my career. Beginning with a general urology practice, from the late 80s on, my practice focused on prosthetics. Finally, in 2004, I abandoned all urological practice except the installation of devices for impotence and incontinence. I prided myself on perfecting surgical techniques to promote easier, safer, and quicker implantations. Some of my ideas were paradigm changers. Other innovations were not such game transformers and have been relegated to the list of the top 5 surgical things that I wish I had known earlier in my career. With this invited commentary, I share with you the lessons learned from a 45-year practice in the field of prosthetic urology.

NEVER IMPLANT A STRANGER

In the 90s I was fully focused on prosthetics. Yearly I did 300 IPP in my practice and another 200 surgeries proctoring physicians in other cities. I was young, headstrong, and considered myself bulletproof. I implanted anyone who wanted an IPP...frequently determining the need and booking the surgery on the first visit. In my older years, I have been burned enough by impulsive surgeries and the unhappy patients who result to reconsider this practice. I now postpone difficult patients or even refuse to operate them.

There is a system in my office to weed out patients with unrealistic expectations. If any staff member, be it receptionist, nurse, or physician, is suspicious, they speak up. That patient receives conservative therapy for a few visits. I have learned to avoid surgery in the patient who sobs when describing his penis. I have figured out that the patient who admonishes me to "*make it as long as you can, Doctor*" will be high maintenance post-operatively and frequently will end up dissatisfied with his outcome. I have learned to preach realism. "*It will be functional but will not look or perform*

like you were 25 years of age." Years of experience has taught me to never implant a stranger because if you do surgery upon a patient with unrealistic expectations, he is your patient for life. His expectations from the surgery (of which you were unaware) were not met in his mind. You were the last person who touched him and the last surgeon who operates upon this patient, gets him. You created the Frankenstein; now live with the monster. The first thing I wish I had known earlier about prosthetic urology is that just because the patient wants an implant does not mean he is a good candidate. My final warning is if you create an unhappy patient, you need to see them more often! Even though it is humiliating and time-consuming, spending time with dissatisfied patients is your most powerful protection against a lawsuit. Nothing spawns a lawsuit faster than becoming impatient and ignoring their concerns. After seeing them repeatedly, eventually, they get better...trust me, they all do...and they, exclaim, "*Doc, do I really need to come back next week? I think I am better.*"

TREATMENT OF ERECTILE DYSFUNCTION AND PEYRONIE'S DISEASE WITH IPP

The original Scott inflatable cylinder was simply a silicone balloon. Cylinder aneurysms developed in areas of tunica weakness (Figure 1). As the inflatable penile implant became more popular, the need to address crooked penises in patients with erectile dysfunction and Peyronie's disease arose. The IPP without adjunctive measures was not the answer. For straightening, Dr Eduardo Austoni popularized plaque excision, penile disassembly for lengthening, grafting of the defect, and installation of rods or IPP to address the curvature.

This was considerable surgery fraught with a number of disfiguring complications. In the mid-80s, AMS (formerly American Medical Systems, now Coloplast Corp, Minneapolis, MN, USA) introduced a new cylinder construction employing a layer of strong fabric between 2 layers of silicone. Simultaneously, Mentor, a breast implant manufacturer, introduced a competitive IPP with polyurethane cylinders. Both of these cylinders were a marked improvement over the original Scott model—stronger, more rigid, and less likely to bulge in areas of tunica irregularity. I began to use these cylinders as a fulcrum to correct the crookedness. I termed this procedure "modeling" and published the technique in 1994 with Dr Delk.¹ Initially, the simplicity of the procedure...cracking the plaque using the rigid cylinder as a fulcrum...was met with a storm of criticism. By 2001, when we published long-term follow-up of this treatment as an adjunctive measure for straightening residual curvature, the surgical maneuver had become the gold standard.²

Received January 11, 2018. Accepted February 15, 2018.

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<https://doi.org/10.1016/j.jsxm.2018.02.017>



Figure 1. Original (1973–1986) single-layer Scott cylinder with aneurysms. Figure 1 is available in color at www.jsm.jsexmed.org.

There were some cautions with the modeling procedure. The penis was not completely straight the next morning when viewed by the patient. We only modeled twice because we found that ≤ 30 degrees of curvature would correct to completely straight with implant usage over the next 8–12 months. Similarly, hourglass deformity and areas of cicatrix would correct to a completely cylindrical penis with recurrent inflation. There was a small (4%) risk of urethral damage at the time of modeling and in the post-operative period due to the intrinsic weakness of the tunica albuginea at the fossa navicularis area.

High-volume implanters began to experiment with other adjunctive maneuvers to achieve a completely straight penis the next morning and to avoid the possibility of urethral damage by the cylinder during the forceful modeling. Within the last 5 years, multiple adjunctive procedures have come to light. Morey³ published on plication stitches to be tied after cylinder inflation. Perito and Wilson⁴ published on scratching the plaque with a hook-bladed knife prior to cylinder insertion. I have used both of these techniques with success. I must admit the advantages of a completely straight penis the next morning is very tempting and I find myself embracing these newer adjunctive procedures. In addition, I have not damaged a single urethra with any of these procedures. The second surgical thing I wish I had figured out earlier in my career was adjunctive procedures other than modeling may be safer and more efficacious than the adjunct I popularized.

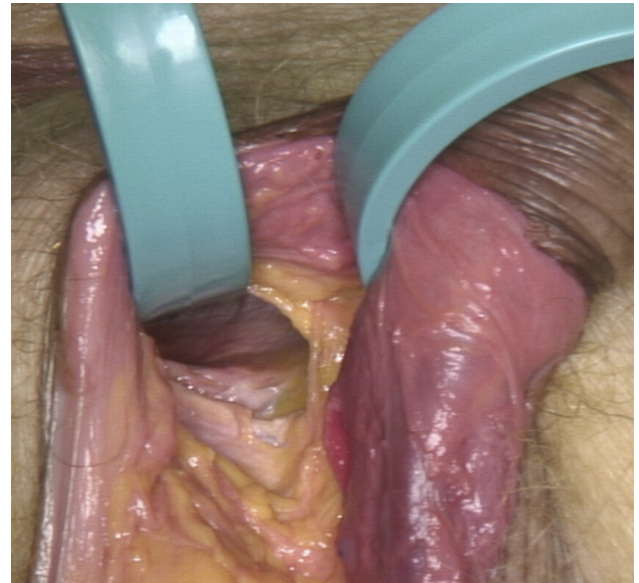


Figure 2. Cadaver study showing transversalis fascia ensuring reservoir will be beneath abdominal musculature if passed with a long clamp. Figure 2 is available in color at www.jsm.jsexmed.org.

ECTOPIC RESERVOIR PLACEMENT

There are lots of bad things that can happen during reservoir placement in the space of Retzius. Viscus and vessel injury, uncontrolled bleeding from pelvic vessels, iliac vein compression, and inadvertent intraperitoneal location are complications that can be life threatening. Because of the complication of a bowel fistula following IPP, I searched for a safer location for the reservoir/balloon component. After the turn of the century both implant manufacturers enhanced their devices with lock-out valves to prevent auto-inflation. No longer was an actual space for the reservoir required. After lock-out valve availability, I began placing reservoirs/balloons in patients with hostile pelvic anatomy in the low abdominal wall, anterior to the transversalis fascia but posterior to the muscles of the abdomen.⁵ I placed the reservoir with my finger breaking through the back wall of the inguinal canal. Unfortunately, many of these components were visible, palpable, and groin hernia was a frequent complication.

Perito and Wilson⁶ published on placing the reservoir ectopically through a long nasal speculum, which allowed a higher location but occasionally components were visible and reservoir hernia still occurred rarely. Morey⁷ began using long lung-grasping forceps to get the device even higher in the abdominal wall directing it medially to nestle under the formidable rectus muscle (Figure 2).

The implant companies facilitated ectopic placement by developing IPP reservoirs that were flat when full, diminishing their detection by the patient.

Ectopic reservoir placement allows most of the worst complications of penile implant surgery to be avoided. I am now placing the reservoir high in the abdominal wall on virtually every patient

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