

A SIMPLE WAY TO MANAGE PROXIMAL CORPOREAL PERFORATIONS

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ÖZET

Yarı-sert penis protezlerinin iktidarsızlıkta kullanılışı rutin ürolojik ameliyatlar arasına girmiştir. Protezlerin emplantasyon teknikleri çok iyi bilinmektedir. Bu ameliyatların komplikasyonlarının az olmasına rağmen, ameliyat esnasında karşılaştırılan problemlerin halli için yayınlanan yöntemler, az protez emplantasyonu yapanlar için komplike sayılabilirler. Karşılaştığımız bir vaka da kullandığımız yöntem, protezi PDS dikişlerle corpus cavernosumun tunikasına iki dikişle tutturmak olmuştur. Bu basit yöntem başarılı bir sonuç vermiştir.

SUMMARY

Anchoring the semirigid penile prosthesis to the tunica with a couple of PDS sutures in a cases of proximal tear of the corpus cavernosum has proved to be a simple and reliable solution for the management of similar cases. The literature is reviewed and the subject discussed.

INTRODUCTION

Implantation of penile prostheses has become one of the routine operations in the management of erectil impotence. Techniques for placement of the prostheses are well documented, so are the ways to overcome the difficulties and complications which may rise during or after penile prosthetic surgery (1-4).

We are reporting a case of proximal tear of the corpus cavernosum during implantation of a malleable penile prosthesis, successfully managed with a simple procedure.

CASE

A 57 years old man was admitted for penile prosthesis implant due to diabetic impotence. The corpora cavernosa were approached through an infrapubic incision (5,6). Both corpora were dilated by inserting closed Metzenbaum scissors and then pulling them outwards in a gentle spreading motion, never cutting the cavernous tissue. Measurements of the corporal lengths showed that the left side was 12 cm. and the right side 14 cm. A 12 cm. long rod was inserted into the left side and a 12 cm. rod + a 2 cm. rear tip extender to the right side. The left side rod well positioned under the glans. Despite the longer rod inserted to the right side its tip was found to be about 1 cm. far from the coronal sulcus. This rod was removed for re-measurement of the corpus. The sizer entered the proximal corpus without any resistance more than 10 cm.s because of the tear of the crus. A 12 + 1 cm. long rod was inserted again with its distal part positioned properly under the glans. This rod was fixed to the tunica albuginea with two sutures using 3-zero PDS, passing though the tunica and the silicone rubber (Fig 1). Then the tunical defects were closed. Postoperative period was uneventful. No hematoma developed in the perineal area and the patient was discharged the 5th postoperative day. He was advised not to bend the prosthesis or try intercourse for three months. The follow-period was one year, visiting us every 3 months. During all his visits the rods were in place and his sexual performance adequate.

DISCUSSION

Most candidates for penile prosthesis implants have anatomically normal cavernous bodies which

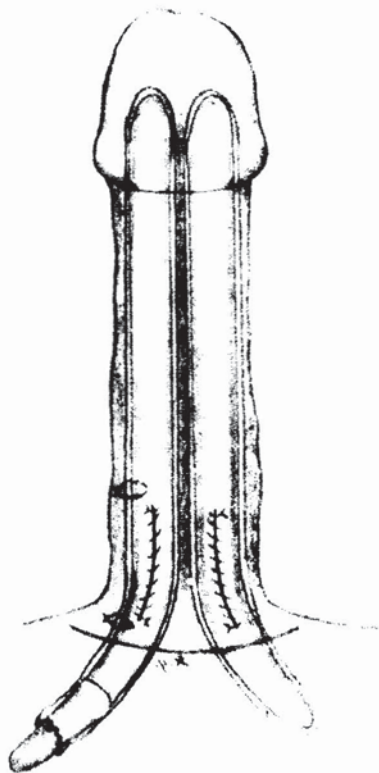


Fig 1: The anchoring PDS sutures passing from the tunica albuginea, taking deep bites from the rod.

have to be dilated prior implantation. Dilation of the distal corpus cavernosus is an easily controllable procedure. However the proximal corpus should be dilated carefully because it can be easily perforated either during dilation or insertion of a longer than needed semirigid rod. Perforation is suspected when the dilator fails to seat solidly against the ischium or when to proximal measurement exceeds too much the one of the controlateral side. It has been suggested to implant the prosthesis even when the perforation is recognized during surgery, but the perforation is small, hoping that it will heal during the 6 weeks the patient is not allowed to use the prosthesis (7).

Direct surgical repair of the tear needs a separate perineal incision after repositioning of the patient and increases the risk of infection. This repair is not advised because it may suffice only temporarily and a new perforation and proximal migration may recur (8). Suture obliteration of the proximal corporeal lumen, distal to the perforation is also an alternative but this maneuver sig-

nificantly shortens the prosthesis and may cause loss of stability and improper fitting of the prosthesis (7). Stapling or sewing of the prosthesis directly to the ischium or its perioste may hold it in place but cause extreme pain or the suture may tear of the prosthesis (8). In recognized perforations the implantation can be delayed for 6 weeks until spontaneous healing of the tear occurs. However a dacron windsock can be sutured to the corporotomy to contain the proximal end of the prosthesis (7-9). This technique is also recommended by the manufacturers who consulted several long time implanters instead of aborting or delaying the implantation (7, 8, 10).

The solution we are presenting is a much simple to perform than the windsock technique which should be preserved in cases when using inflatable cylinders. The PDS (Ethicon Ltd.-Scotland) is a monofilament synthetic absorbable suture which retain its original tensile strength much longer than other absorbable braided sutures. Its absorption is minimal until about the 90th postoperative day where the others are entirely absorbed during 60-90days. Until the PDS sutures start to be absorbed they hold the prosthesis in place. During this time the tear heals and sheath forms around the prosthesis.

Unrecognised or late perforations due to the development of weakness of the tunica albuginea because of the pressure of the prosthesis, should be repaired using the windsock technique. However in these cases, if the distal tip of the rods can be manually manipulated to reach the mid-glans position they can be held in place using a Babcock forceps. Then through a small lateral skin incision of the penis the anchoring PDS sutures can be passed from the tunica albuginea taking a deep bite from the prosthesis using a round bodies needle to prevent tear of the silicone rubber. The whole procedure can be performed under local anesthesia of the penis.

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