Simultaneous Inflatable Penile Prosthesis (IPP) and Male Sling Placement: Aiding in a Faster Return to Patient Quality-of-life

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Hello, and thank you for joining us for this Webcast. I am Dr. Arnold Bullock, Professor of Urologic Surgery at Washington University School of Medicine in St. Louis. We’re here today to show and discuss the Simultaneous Placement of the Titan Inflatable Penile Prosthesis and the Virtue Male Sling for Male Incontinence. Joining me on this panel of urologists are my three colleagues: Dr. Alan McCool from Urologic Associates in Dothan, Alabama; Dr. Eugene Rhee from Southern California Permanente Medical Group in San Diego; and Dr. Christopher Steidle from Indiana School of Medicine. Gentlemen, thank you for taking part in this program; and let’s begin by talking about male incontinence and the Virtue male sling. Let’s begin first with Dr. Rhee and let you introduce the Virtue sling.

Sure, be happy to. The Virtue male sling was created as a response to the needs of the incontinent male. We currently today have the artificial urinary sphincter, and male sling technologies have really seen an impressive movement in terms of its evolution since its beginnings years ago. The thing is in the last ten years, we’ve had generational changes with the sling. The latest one is the Virtue quadratic male sling. And I mention quadratic because it addresses two things here. We’re trying to achieve a longer length of compression of the urethra. So the jump here is that we think that with that, you’re having a better advocacy with the sling. There’s a transobturator component, and there’s a prepubic component. The transobturator component gives you the rotation of the proximal bulb of the urethra to create that added coaptation of the sphincter that’s necessary on these types of slings. The other component to the sling, which is original, is the prepubic portion; and that prepubic portion gives it compression – the passive compression I think that really creates a bigger footprint in regards to handling the more severely incontinent male.

You’re going to hear today, I think, different ways we’re doing this – unique and novel; and they’re very exciting. The thing from the patient’s perspective, it’s an outpatient surgery. It is done immediately. There’s no mechanical device he has to use. And he sees the results as soon as that catheter is out. And I think that that’s really the key element here is patient safety, patient convenience, high patient satisfaction rates, along with the surgeon satisfaction that we’re going to explain why we think that’s so high.

The Virtue sling seems to have a dual effect for creating male continence, and all through relatively small incisions.

That’s good. A small, perineal incision and just four basic needle sticks to bring the sling through. That’s correct, simple as that. So for the viewers I think, let’s bring this animation up to see what we’re actually talking about. So what you’re seeing here is a surgeon ease of use. So surgeons have created this for the surgical procedure, so it’s intuitive. The thing is that we use one passer, as you can see here, with a nice handle. There are two slots in the end of this needle passer. Each of those slots is for a base on the body habitus of the male. The green thread sutures that you see here are loaded onto the passer. The blue sleeves are the prepubic arms; and the clear sleeves – the horizontal sleeves - are the transobturator arms. So as you can see on the design of this particular mesh that we’re creating that whole length of compression. This is an inside out maneuver. So it’s a very simple maneuver. It’s safe because you’re using the bone as your landmark. The other aspect of this animation is the prepubic pass from above with those puncture wounds. So these little puncture incisions are done from above, and then you just bring the blue sleeves up to create this elevation and compression, if you will, of the Virtue male sling. So this is brought through and then it’s tunneled, and it lies in subcutaneous tissue for better anchoring. So this particular sling we’re finding, again, is an outpatient procedure done with remarkable ease for the patient and the surgeon who’s performing this particular surgery.

Well, Dr. Rhee, the animation makes it look fairly simple and straightforward through fairly small incisions. I wonder, Dr. McCool, now that we’re about to watch the real procedure, at least a segment of it, how about if you introduce the patient that we’re going to be demonstrating this procedure on.
This is a gentleman in his mid-sixties who's several years status post robotic prostatectomy. He goes through about two or three pads a day, depending on activity. And he's been impotent for several years, including prior to his prostatectomy. He is a candidate for the sling because he did demonstrate on cystoscopy the ability to coapt his sphincter, and that's the way I evaluate all the patients. You want to make sure you do cystoscopy to ensure there's no blood in a contracture. Once I fill their bladder up, I'll actually go to the restroom with them, watch them void and make sure they can slow their stream. If they have some sphincter function, I believe they're a good candidate for the sling. And we can go to the surgical procedure now if you'd like.

Yes.

I've made a mark there outlining where the turn of the bulb is, and you want to make your incision below that, almost to the anus. And you don't want to make it so proximal towards the scrotum that you get the scrotal contents in your incision. But as I'm cutting down with the Bovie, I've got the catheter between my thumb and forefinger the entire time until I actually see bulbouspongious muscle. And that's where we really stop our urethral dissection. We don't open up the bulbouspongious muscle, and that's a very important point.

And you can see the muscle there in the middle. And then what I'm going to do is I'm going to separate the tissue on either side of the bulbouspongious muscle until I can palpate the ischiopubic or inferior pubic ramus. Oftentimes I'll try to identify the corpora as well. The corpora actually lie anterior to that ischiopubic ramus there. Here I've got a space between the urethra and the ischiopubic ramus. And with retraction on the urethra at twelve o'clock, I'm dissecting until I can palpate the central tendon. And I'll take the central tendon down for approximately a centimeter/centimeter and a half. But I try not to take it all the way down so it provides a backboard for that elevation, which allows us to have a little compression in that area as well.

And on the outside here, from my transobturator arms, I'm outlining where the adductor longus muscle is. And there's a spot just below that that we call the "sweet spot," where you want to try to bring your introducer out in that inside out fashion. And before you pass it, I always put my finger all the way along the path, and you want to attach your suture to the end of the trocar in the T-slot, and then I'll hug the bone there, and then I'll pop it up through the obturator foramen. And as long as you stay on that bone, there's virtually no risk of vascular injury there. And I'll make a small incision -- it's just a stab incision -- to bring the trocar through the skin.

Then we'll do the same thing on the other side. And again, I've got my finger along the entire path protecting the urethra, and I just hug the ischiopubic ramus; and I'll pop it through the obturator foramen, making sure to stay right on that bone as I do that. And oftentimes here we'll have a little increase in our bleeding, and that's actually very normal. And the key to really getting that bleeding stopped is you just tension your transobturator portion of your mesh at this point, and that really compresses that bleeding; and it's never been a problem.

Now, I've tensioned my transobturator arms; and now I'm going to decide where I want my prepubic arms to lay. So what I do is I just lay the blue arms up on the pubic area, and I just see where they fall; and that's typically where I will put the prepubic stab incision. Especially if I'm going to do a simultaneous implant, I will make sure these incisions are just a little bit more lateral to stay out of the way of my infrapubic incision for my infrapublic implant. And this is an outside in pass. There are no structures here you can get into. The cord structures in the testicles are medial. Again, this is a subcutaneous pass, not a retropubic pass. There is no danger in this area. Then we'll hook our prepubic arms to this T-slot and we'll pull it through. And then, again, the same thing on the other side. And I can basically take my finger all the way up to my stab incision subcutaneously or just follow my introducer all the way down.

Now comes the tensioning portion of the procedure; and I like to tension all four arms simultaneously. And the nice thing about this mesh is it is very surgeon-friendly. You are able to imprecate this mesh. If you feel like you don't have adequate compression, I will often imprecate this mesh with a couple of vertical mattress sutures right in the midline just to make sure I get that adequate compression. Oftentimes I don't have to do that; but I would say 30-40% of the time I will imprecate this mesh in the midline just for a short distance, about two-thirds of the way down the mesh, to make sure I get that adequate compression. And I use [tuprolene] for that.

What I'm doing now is I'm tunneling my arms. There are several ways to do this. I'm actually tunneling my prepubic arm back down to my transobturator arm now so that I can fixate this to my TO arm. Now, Dr. Rhee in a short time, he'll show the way he fixates his prepubic arms, which that's the way I'm doing it now. I think as long as you fixate the arms, it's really not an issue. But I think that's very important now, we realize, to make sure that we have that adequate compression with those prepubic arms.

I notice that you're keeping the sleeve on. I do keep the sleeve on. That's something relatively new. It just makes it much easier to tunnel. So I actually keep the sleeves on. It prevents buckling of the mesh and fraying of the mesh. So it appears to be a very dry field. You mentioned it's an outpatient procedure. So chances of it bleeding or having postoperative hematoma --

You know, once I've gotten the mesh in, I have no trouble with bleeding. It always stops. Very rarely have I had to admit a patient because of this.
What I'm doing here is just part of my initial fixation procedure. As you can see, I've brought my prepubic arms out of my TO incisions; and I'm suturing those two pieces of mesh together. And that's just a way of fixating the prepubic arm to my TO arm. And then what I'll do in a second is I'll tunnel -- as we always do, I'll tunnel my TO arm through a separate tissue plane out my perineal incision. And then I'll actually end up suturing my TO arm back to my mesh. And by doing it this way not only have I fixated my prepubic arms, you have to make sure you keep tension -- your assistant needs to keep tension on that prepubic arm the entire time; but by doing that I've got a lot of that mesh in contact with subcutaneous tissue for a fair amount of ingrowth. So in the short term, it just gives it more subcutaneous tissue for the mesh to adhere to, to prevent loosening of the tension.

That's exactly right. And I do want to stress that I don't think it really matters if you do it this way or not. I think the key is you've got to make sure you fixate those prepubic arms. We now know that. And again, I'm doing the same thing on the other side. We're just tunneling that TO arm as we always do. We tunnel that TO arm back into our perineal incision.

It's as if this Virtue sling has given you two slings in one. Yeah, it's like giving you the InVance sling, the compressive portion, and then our Virtue sling, the elevative portion.

And so now we've got our TO arms tunneled back through our perineal incision, and I personally suture them back to the mesh which prevents any migration of the body of the mesh along the urethra. I typically don't suture the mesh to the urethra, to the bulbosphongiosus muscle. If I felt that there was too much play or too much migration, I absolutely would anchor it to the bulbosphongiosus muscle if I needed to; but it's very rare that I need to do that. And I like to also -- when I'm tensioning the sling -- actually lower the legs a little bit, which gives me more elevation. I also like to take the catheter out as well. And I often will not ever replace the catheter after doing that.

What are the chances of a patient going into retention in the short period? And you mentioned you tend not to replace the catheter. What about a 12 French or 14 French?

I think that's fine. I just don't do it. Patients really don't want a catheter. In only two patients have I had to replace a catheter. And when they came back for their voiding trial either the next day or the next couple of days, they were all able to void.

I think the advantage of this Virtual sling and the male urethral sling is that a patient does not have to operate the device every time he wants to void.

That's exactly right. But again, compliance is very important. After this procedure, you've got to make sure no lifting greater than a gallon of milk for six weeks. Very important.

Now, you mentioned this patient was using about two pads per day. So what's the max? Give me an impression of how much incontinence a man could have to make this a reasonable option for him?

Right. Well, the hardest patient to treat to me is the patient who only goes through one pad per day. That patient is actually tough to make better. As long as I demonstrate sphincter function, the ability to coap their sphincter, I really don't have a limit. I know that patient that goes through six or seven pads a day, completely wet, if I get them down to one or two pads a day, they're going to actually be fairly happy. Now, my goal is to make them dry. But as long as they can demonstrate sphincter function, I will try the sling.

Now, Dr. Rhee, Dr. McCool showed multiple places where he fixed the different arms of his sling. Sure.

So obviously, fixation and placation of the sling over the urethra is pretty important.

Right, sure.

What are some of the techniques that you've used as an experienced implanter to improve your continence rates?

Sure. I stress this is -- we've said before the evolution, and we're learning better ways to make this better even. And this is a customizable sling. And because it's customizable, you have different surgeons who can say, Look, I can suture this together and really anchor this down; as far as that's concerned. The key element is I think we've discovered by measuring retrograde leak point pressures, which is a correlation that's been validated with mini urethral closure pressure that the prepubic arm has to be fixed in some form or fashion.

Yes. However way you do it is really "dealer's choice," if you will.

Okay.

The thing that's the most important to understand is that you actually have good soft tissue anchoring with the suture. And that's really where I think we're getting great results with the more severely incontinent men.

All right. Let's go to your clip, and let's see how you've demonstrated your fixation technique.

Sure. So this is for teaching purposes, so this is a cystoscopy. And we take this down very similar -- you'll see that it's very similar to Alan McCool's technique as well. You know, just take the -- get down to the BC muscle.
Once you get down to that BC muscle, which we find in the upper half of that incision, I'll take this down, spread apart, expose the rami as you've seen with the other surgical video. And so what I'm pointing out here is this is the patient's bulbar urethra pointing to us. On that is the rami on the patient's right side. This is an ingenious retractor. It's made by Applied Medical. It's called the Alexis retractor. I use this for all my prosthetic surgeries, including penile scrotal, infrapubic, as well as this perineal surgery for any kind of urethral case. So what you'll find is this is a wound retractor. And for those who are familiar with laparoscopic hand-assisted nephrectomies, this is no different than what we've been using for those cases. So as you can see here, it brings the bulbar urethra right in front of you.

So what I'm doing here is basically showing us the isolated bulbar urethra and the rami. And that's a landmark. So now, semilunar incision -- we take this down with the Bovie, just creates immobilization proximally. Again, you're doing this about a centimeter, centimeter and a half as far as that's concerned. This time elapse is about -- at the most ten minutes at this point in this procedure. So when we get to this point here, then you'll see the blue sleeves and the horizontal sleeves here. I'm illustrating the slots that we mentioned before. The distal slot is for the thicker patient. So we'll pass it right underneath the bone -- again, the bone is the landmark -- inside out maneuver, just below the adductor insertion. And you can feel it. You can palpate it right there, and you just make a puncture wound; and you basically pop that through. And then you'll see, I actually put a knot at the end of this so that you can actually grab the knot. That's a little pearl, but the bottom line is that you pull this. And you're right; you get some bleeding, as you see here. Once you pull the mesh, it will stop as far as that's concerned. Repeat that on the contralateral side. And as you see here, the retractor -- unlike the Lone Star retractors, you can't -- you have to take down the Lone Star retractors to pass through this needle. So with this retractor, the retractor stays in place. Now, how far lateral to the symphysis are you?

In terms of the symphysis itself, you're probably about two centimeters lateral from it, as far as I'm concerned. You're about a centimeter lateral from that groin crease, as far as that's concerned as well -- from the skin. Puncture wounds, prepubic arms -- we go from above to below. Using your non-dominant finger, you can actually feel the tip of that needle pop through. Again, the testicles are more medial and anterior, so you're not going to hit those. And basically you bring that up, /INAUDIBLE/ the suture, blue sleeves.

And again, the meat of the case is very similar to McCool's case. The thing is, is that how we fixate it -- I tend not to do too many things to this mesh except for the propubic fixation. So I'll pull, just like Dr. McCool does, where we basically pull the transobturator arms, and then we pull the propubic arms. And then I'll actually cut the sleeves as I throw irrigation down the sleeves to irrigate the subcutaneous tract. And then we pull the sleeves off because I like it biting the tissue as I pull the mesh.

Do you have antibiotic in the irrigation -- ?

Yeah, vancomycin as far as my cocktail is concerned. So this is a retro /INAUDIBLE/ impression I wanted to illustrate to the viewers. So this is a way you can objectify how -- to make sure that you at least have the minimum tension required. Again, as you pull the catheter out to inflate the balloon in the fossa navicularis. This is 60 centimeters that you measure on the IV bag from the level of the pubic symphysis to the top of the water level of the IV bag. And so then as you tension, you're pulling on the propubic arms, you're really creating -- you want to make sure that it's at 60 centimeters of water pressure that the dripping stops. So at that level, at that tension, again, this just tells me what is the minimum tension I need. Not that I'm worried about retention; I'm worried about, Can I get this guy dry? So really what you're trying to do here is trying to create this [urivate] stitch with the O-/INAUDIBLE/ as you see here. And what it is, is this is the fixation suture you were talking about. So you really -- you've got to have a good, meaty bite of this.

And exactly what are you grabbing with your suture?

You're grabbing the surface of the bone -- not into the periosteum, but just deep enough to where you can feel the bone.

And is the urethra between those two sutures?

Yes, the urethra is right in the midline, exactly. So where that suture is, is where the junction of the rami meet the pubic symphysis. And it's facilitated, as you can see here, by [Dever] at the twelve o'clock position of the retractor. And you may need that to really just get good exposure above. But as you can see, the kind of hot-dog-in-a-bun compression that you're getting here -- you're getting really good compression at the midline. So once you tie this down, I'll just cut this and that's it. I mean, the dripping stops as you can see here. So this tells me I've reached my minimum requirement.

So on the cystoscopy here, this is to illustrate -- look at the length of compression you're creating here. And that's why I'm thinking from the standpoint of efficacy, we're seeing some good results here. So I'll vary this in subcutaneous tissue through using a tonsil through this peritoneal incision, grasping the end of that transobturator arm, as you see here. And like I said, Alan likes to fixate this; and some guys like to do that, as far as that's concerned. I think I'll start doing that because I agree, the mesh can migrate.
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Yes.

So as you see the results here, you can see I’m illustrating the length that you’re creating, this kind of coaptation that occurs with the mesh. And as you see here, you can throw those impregnating sutures if you’re not happy with the tightness of the mesh. And this is the retractor. Just flip it, grasp the inside from inside -- the green ring -- and it slips right out and you’re done with the case. You just close.

Well, the beauty of the Virtue sling is that the patient does not have to do any operation to void each time. He doesn’t have to operate a pump. He just goes to the boys’ room and goes. In your experience, the chance of having incontinence after the Virtue sling?

So in my experience, the dry rate – when I say, “dry rate,” it’s like 24-hour pad rate for my practice. We’re seeing a 70% dry rate in regards to that. And there’s a learning curve to this. You’re getting better and better at it.

We’re all getting better and better at it.

Yes.

And I think what we’re finding is, is that the dry rates are even higher now for those guys who leak one or two pads. I think that the guy who has radiation, bladder contracture – who’s got diapers – you know, is a challenging case; but we’re confident that using a male sling is a good supplement to our armamentarium in male incontinence.

Well, let’s try to clear up a few concerns that the novice implanter might have.

Sure.

One, what’s the chance, in your experience, of getting an erosion? And keep in mind that we’re placing this very proximally on the urethra, where posteriorly it’s much thicker.

Right. So a couple things -- and Alan and Chris can chime in here. But number one is this, is that we leave the bulbocavernous muscle intact. So we put this mesh, we design it to say, Look, put the mesh in, but have plenty of tissue in front of it. And we haven’t seen erosions in regards to speak of for the Virtue sling. The other thing I might add is that the prospect of multicenter trial that’s enrolled eighty patients over that -- it’s close to a year now -- is that we haven’t seen any erosions in that population either from a multicenter trial.

Dr. Steidle, in your opinion, the greatest fear I think of a novice implanter -- or someone who hasn’t implanted before -- might be placing the needle transferring suture up into that obturator fossa. Anatomically, the chances of hitting a major vessel?

Extremely, extremely low. And what we’ve found is on the cadavers -- the cadaver studies -- is that we’ve placed our finger -- as we saw in the video -- we can literally feel the back of the ischiopubic ramus; and you’ll find that you almost have to try to hit -- you’ll have to actually try to hit the back of that with that needle. So unless you really try to do it, I don’t see there’s a possibility.

You know, one of the concerns when we first started doing these combination procedures was which one to do first. So let’s get all three of your opinions as to your sequence of placing the two devices.

I personally have done a little over forty Virtue cases, and about half of those have been combination procedures. I just personally feel I think you need to do the sling first. I think the incontinence is what really affects the patient’s quality of life the most. And we haven’t had any complications yet; but if, for example, you were to have a urethral perforation during your dissection, you can end up with a prolonged catheter. And I don’t want to have a prolonged catheter in a fresh implant. Plus, you’re going to have some urine leak in that area; and I don’t want any urine leaking around my fresh implant. So I put the sling in first. I don’t like any shared tissue planes. I don’t want a complication with one to cause a complication with the other.

Mine is purely in terms of efficacy. Like obviously a man want’s to be dry. That’s the number one goal when we’re doing this. And I urge the viewers to understand something, that you can’t ignore the incontinence component of this. These patients want both. And to do it simultaneously, there’s no problem with that. I choose to go with the male sling first, just what Alan said. You really want to have good coaptation, and then you can slide the rigid extenders down. And it won’t be a problem. In fact, it will enhance because the rigid extenders are seated within the sling itself, that you’re going to have an enhanced probably coaptation.

Dr. Steidle, let me ask your opinion. So we tend to leave the patients without any catheter after we’ve placed this Virtue sling.

Right.

But then we go and put the penile prosthesis in, and we’d like to identify where the urethra is before we make our corporotomies. So what is your technique, and then how about you lead us into the second part of this dual combination procedure, the Titan penile prosthesis?

So what we do is very, very similar to what we’ve heard; and I completely concur with what you’ve heard. I believe incontinence is important, so we do the Virtue sling first. We close. It’s almost two separate operations. We close, we place /INAUDIBLE/ -- we really want to minimize any chance of infection. Then we’ll make our infrapubic incision. We place our penile implant. We will have drained the bladder. So once we’ve drained the
bladder, we don't put a catheter back in. We do these procedures without a Foley catheter – both the implant and the Virtue – once we've drained the bladder. I mean, we minimize that risk of urethral damage. Well, I actually take a 16 French catheter and slide it in just into the penile urethra only while I'm doing the corporotomy portion, because the idea of getting too close to the corpus spongiosum doing my implant. Do you place one even partly while you're doing your implant? I don't. And most of these patients are post prostatectomy patients. Their bladder is scarred where it's going to be. And by replacing a catheter, I just don't see how you get that scarred bladder off the interior abdominal wall. So that's just not been a concern of mine so far. No, I mean when you're making your corporotomy. Sure. Well, through the infrapubic incision – Oh, I see what you're saying. I actually put a catheter in. So you see some variation here from the catheters. It's all theoretical. But I think from my standpoint, I do like to palpate where the urethra is in position, as far as that's concerned. Yeah, so I do a peno scrotal approach also. And I tend to place the catheter, but I don't go past the area of the sling. Which I don't probably do myself.

So, Dr. Steidle, how about you introduce the Titan inflatable penile prosthesis? Okay, well we've got an animation here; so we'll kind of -- and this is to show the concomitant placements. The patient's had the Virtue already placed, and now we're going to place the Titan implant. And we're showing the one-touch release valve placement, as you can see. So the inflatable penile prosthesis – as urologists, there are different techniques that we have to place the implant. As we've already mentioned, some place infrapubic; and many of us know that peno scrotal is actually a better way to do it. And so there are mixed opinions – the pros and cons of each approach. Dr. McCool, what is your technique and why do you do it infrapubic? Again, I think it's going to be a serious implanter, I think you ought to have both techniques in your armamentarium. I typically do about 90% of my implants infrapubic. But if I have a morbidly obese gentleman or if previously infected through an infrapubic, I will do it peno scrotally. For the combination procedure, I just like to keep all those tissue planes separately. Like Dr. Steidle said, I like to keep them two completely separate operations.

And, Dr. Rhee, like myself you go peno scrotal. Yeah, I do peno scrotal and I do infrapubic. The breakdown is probably about 60% peno scrotal, 40% infrapubic. And in regards to this particular concomitant placement of the Virtue and the Titan, it doesn't matter in terms of which approach you use. I like the peno scrotal because as far as the preparic arms, you can really see; and you can feel the prepubic arms as it's placed in there, as far as that's concerned. But it's a matter of preference. I don't see -- an infrapubic can be done the same way. And I think it's very important. If you're real comfortable with one way, especially when you're trying a new procedure, you'll get a real sour taste if you try to change everything you do. Stick with what you do. Well, Dr. McCool, I know we have a video of you doing the procedure from the infrapubic approach. And how about we start the video and you animate it for us? Sure. And this is the same patient that we just did the sling in. So I don't redrape. I actually lower the legs to 90 degrees with the table, and I just do another alcohol-based prep. I trained with Mulcahey, so I use Mulcahey technique, plus Paul Perito technique, plus a little bit of my own. And you can see my prepubic stab incisions laterally. And they're very lateral, so they're well out of the way of my infrapubic incision. Now, we're looking from the head looking down. That's correct. And again, I make a small incision; it's about three or four centimeters.

You mentioned your alcohol prep. Dr. Steidel, why don't you tell us about the prep that most of us are using nowadays? Well, I also use an alcohol-based prep. I'm a firm believer in alcohol as being probably one of the best ways to deal with the grand positive. And here on the patient's right side, you can see the neurovascular bundle medially. I've got my right corporal stay stitch just lateral to the neurovascular bundle, and we're putting our second corporal stay stitch. I always start with two stay stitches. If I don't have a water-tight closure, I'll always add some more at the end. And again, this is the patient's left side. You can see the neurovascular bundle in the middle. I'm going just lateral to that. Of course a lot of people say that that's their fear, injuring the neurovascular bundle. But you sure got down to the corporal bodies pretty quickly there. Yeah, I did; and that's why I like this procedure. And if you're placing a stitch vertical through the neurovascular bundle, you're still not going to typically hurt anything. And here I'm dilating with my Furlow both proximally and distally. And again, you can see the Virtue does not come into play here whatsoever.
Do you irrigate your wounds with an antibiotic irrigation?
I do. I use typically – when we have it, I’ll actually use a Bactrim irrigation. If not, I’ll just use a GU irrigate and some genomycin.
And we’re dilating distally here on the right side.
These are the Hegar dilators. Do you have a preference?
I don’t. These are the Hegar dilators. And I will typically dilate with the Furlow. If it’s somewhat of a narrow penis, I will go ahead and go straight to a 12. If it’s not, I don’t dilate any further. I’ll just use my Furlow if the measurement went easy. Here is something I’m doing now. That’s a quarter percent Marcaine without epinephrine I’m injecting directly into the neurovascular bundle. My entire postoperative course has been much better now that I’m doing this – not just immediately postoperatively, but even days out when I take their JP drain out, for some reason. So I’ve got a direct shot at the neurovascular bundle. I inject it, and I’ll inject my skin there as well; and that’s something fairly new.
Now, how much are you injecting again?
No more than 10ccs.
Now, what are you doing here?
Here I’m placing -- just like Dr. Perito has described previously – I’m placing my reservoir. You palpate the external ring, keep the cord lateral to you, and I pierce the transversalis fascia so it’s basically going in the perivesical space. There are several ways to do this. If this goes easy, this is how I do it. If it does not go easy, then I’ll actually put an intrafascial as previously described by Dr. Perito. And I copiously irrigate throughout the entire case.
Now, one of the questions a novice implanter will have is, Exactly how do you measure each side? Do you measure exactly, or do you add more length or subtract more length?
I measure exactly; but if I’m in between -- even though now the Coloplast Titan has the half centimeter rear tips -- I never shortchange the patient. If I’m in between, I’ll round up because when I do a rapid inflation, I can just about every time get that implant seated like I want to without any buckling.
Now, you’re placing your cylinders, and there’s just your stay sutures on your corporotomy.
Correct.
Some people, like myself, I actually place two or three stay sutures on each side so that I don’t have to add any sutures after my cylinder – And the only reason I do it this way is to keep the stitches out of my way.
Okay.
If I need to, I will add another – but my corporotomy is very small. If my Hegar dilator will go through – my 12-inch Hegar will go through my corporotomy, then I’ve got a plenty long corporotomy.
Dr. Rhee, any other tricks? Or Dr. Steidel, I know you do it through the same approach. Any other --?
I mean, pretty much identical. I mean, we do the exact same technique.
The reservoir balloon -- I actually don’t go through the ring. I actually will go in and make an incision right above the pubic symphysis and put in that space.
But honestly, I’m surprised. If you have this approach and you’re sitting right in the midline over the top of the fascia, why not go through the fascia?
Well, you can; and with that transverse incision like this, it’s actually easier to get it through the external ring. You’ve got to really retract to pop through the lineal alba or the midline of the rectus abdominus muscle. Now, if they’ve had bilateral inguinal hernia or /INAUDIBLE/ I will absolutely put it in the /INAUDIBLE/ rectus. And obviously, we’re about to get to the point where you place the pump. One of the advantages of the penile scrotal approach is that you’re directly able to place the pump where you want.
Right.
So tell me some of your tricks or fears of placing the pump.
Well, I don’t really have any fears. What I worry about in this case is it’s a concurrent case with the Virtue. My Virtue is much more lateral. I start with a [Stalay] clamp or a large tonsil clamp, and then I dilate with a very large Hegar all the way to the bottom of the scrotum because, like you said, the last thing I want is a high-riding pump. So I actually dilate, and then I just follow my same path with my nasal speculum; and I will pop my – as you can see, the tip of the nasal speculum is in the bottom of the scrotum. And I really take my time on this portion of the case because the patients really don’t like that pump sitting right next to their penis. So I agree with you. It’s a very important part of the procedure. And then I will pull down again, and you can feel that /INAUDIBLE/ give when you pull.
Any advice as to which way you like the deflation valves of the Titan to be positioned – side to side, front to back? Do you think it makes a difference?
I do them front to back, with the top of the valve pointing anterior, towards the surface.
Any other opinions?
You know, I think the patients themselves for ease of use, I think they can manipulate it pretty easily. The OTR, the one-touch release, it's clear that it's a good advancement in regards to the pump technology. It's much easier to use. Either way, so for us, however way we anchor it, it's not a problem. In the old days, if you remember, you had to hold it and keep it down; but now, it's just one touch. So it's a fantastic advancement. Looks like a beautiful result.

And I do leave a drain. Like I said, I trained with Dr. Mulcahey. We never left drains, but my postoperative swelling is much better without the drain. I've tried the mummy wrap. I just prefer to do the drain. So you leave the drain for how long?

It depends on when I'm in clinic. Since I'm sending them home, if I'm in clinic the next day, I'll take it out the next day. If it's two days, I'll leave it in for two days. If it's a Friday, I'll leave it in over the weekend. But there's never been a study that says a closed suction drain device is an increased risk of infection. So my patients are much more comfortable. And this is a small drain, and it really does not bother them coming out.

Now, I must admit, I keep my patients overnight. They all get admitted as a 23-hour stay. Am I alone in this group with the 23-hour stay?

Mine go home the same day.

Same day? So if they go home the same day, what is your antibiotic regimen pre-op? Do you give the double dose of 320, or what do you use?

For me, I give vancomycin preoperatively, given at least one hour prior to the case. Ten days of Septra is what I give postoperatively for antibiotic coverage.

We do the same thing.

And my hospital won't let me give Vancs, so I use /INAUDIBLE/ genomycin and I send them out on ten days of Bactrim.

So, Chris, what antibiotic regimen do you use?

Same exact regimen.

Okay.

So ours will be – unless they're allergic, we'll use either Vancocin or [Unisonogen]. And we'll always have an aminoglycoside.

So how do you wrap the scrotum? We talked about the mummy wrap being one option. I don't leave a drain. I rarely do a mummy wrap. I usually just use the Steri-strips, fluffy dressing and a scrotal supporter. Any change in how you --?

I use a scrotal support and wrap the /INAUDIBLE/ likes to use FLOSEAL. As far as price goes, the drain's a little bit cheaper. But I think FLOSEAL is an option as well without a wrap whatsoever.

I'll use four-by-fours and a Coban wrap for the penis itself. I'll use the mesh panties for the scrotal support, and I'll put a five-pound bag over that -- if it's an infrapubic, over that site or just for an hour after the case to make sure the bleeding isn't an issue.

So in terms of the implant and pump position, I suggest that the patients manipulate the pump to one, make sure it doesn't get stuck to the skin. What are your opinions as to pump positioning -- how the patient gets the pump to where they want it?

Well, I think number one you've got to put it in the right place. It's very difficult to put -- if you place a pump high in the scrotum, it's almost impossible for that patient to get it lower. But at a week out, I have them tug on the pump several times a day.

Yes.

Now, one of the fears with pump placement is making the subdartos pouch too thin and having a risk on pump erosion. What are your opinions on that -- Dr. Steidle?

Well, what I do is I actually do a slightly different technique. I'll evert the scrotum with my finger and just sweep away the tunica vaginalis and place the pump that way. And so I really don't have them manipulate the pump. It's always very well dependent in the scrotal sac. And nor do I worry as much about fixation of the skin because it's generally where I've placed it.

Well, I think this combined Titan inflatable penile prosthesis and male Virtue sling is an excellent combination surgery. Patients who have had radical prostatectomies very often have both of these complications; and to be able to do it in one setting, getting the impression that we find it doesn't increase the risk and is very effective in both.

So, we're getting at the end of time for this program. And I was wondering if each one of you would give a few points of encouragement and your final opinions to potential new implanters or combined implanters -- just a few of your take home messages and after having your experience with forty combined procedures.

Sure. I think first of all as far as the sling goes -- and Eugene can definitely tell you better than I can -- it's almost surgeon proof. With the quadratic fixation as he's described, it's almost surgeon proof. And the penile implant --
if you just treat it as a completely separate operation, there’s really no increased difficulty with the case; and I
don’t think anyone should be hesitant to try it, whether it be peno scrotal or infrapubic.

Yes?

So for me, it’s more philosophical; and I’ll be quick with this. For the viewers, we create this population. It’s not a
/INAUDIBLE/ population. And there’s a disconnect. And I encourage all of us in our field to embrace this, to
really help these patients that we’ve created. So incontinence and erectile dysfunction is not just the prosthetics
in regards to penile prosthetics. It’s also in regards to artificial sphincters and male slings. And with these
technologies, we’re ultimately trying to restore quality of life. And the patients don’t thank you for removing the
prostate. They’re ecstatic when you help restore their quality of life, as we all have experienced and as I’m sure
the viewers have too. So I encourage them to look at these procedures and really do them on a regular basis.

Well, a few questions. In terms of the ability for a person to begin doing these procedures, what would you
recommend before a person does their first combination procedure?

Excellent question. Chris, what do you think?

What we do is a pretty general workup. We’ll talk to the prospective candidates. We do Doppler color flow
examinations, at which time we’ll do injections. We’ll talk about vacuum erection devices. Of course they’ve all
tried the various medications. But I think in take home, the most important point, the satisfaction rate with these
devices is about 95%. And that really says it all. These are very, very happy people. And you make a difference
in their life, and these are the things that make the difference. And if I had one message for a young surgeon that
wants to do this, it’s that this is the most gratifying thing I do. I lived the days of radical prostatectomies and we
worry about leakage and we worry about this and we worry about that, but these are happy men. These are men
that you see them at the mall, and they wave to you; and you know that you’ve made a difference in their lives.

Dr. McCool, do you recommend urodynamics on all of these patients before putting in a male urethral sling?

I do not. I have found that in male incontinence, especially post prostatectomy incontinence, that it’s helped me at
all. You know, there’s really not a defined abdominal leak point pressure; and they’ve all got ISDs. So
urodynamics have not helped me for these patients.

One of the things as a suggestion to the viewers who are considering doing this is that there are videos available
on YouTube – surgical videos on this. I encourage them also – the Coloplast has been a tremendous company in
regards to helping roll this out with the cadaver labs or with many people who are willing to go out and help these
other surgeons, as far as that’s concerned.

Yes, and I think that that’s an excellent opportunity – to have someone who’s an experienced implanter to be
there, to accompany you for your first procedure. Coloplast has been wonderful at providing such a service. It’s
in their best interest, obviously. The more successful their device, the more devices they’ll place. And of course
we want to see patients have good outcomes and low risks.

Absolutely.

But the videos that we’ve watched here demonstrate that it is safe. I think the greatest fear people have is that
with the male sling that that carrying needle is going to hit some great vessel. But anatomically, if you stay below
the abductus tendon, the chance of hitting a vessel with these low and the suprapubic arms are actually going
above the pubic bone.

Right.

And so I think that the risk of a major injury with either part of this would be very low.

Designed by surgeons for surgeons.

Absolutely.

So I think that it’s a great option we should be presenting to our patients. We should not have patients who are
post prostatectomy walk around with two or three pads per day or more, and not at least hear that these options
are out there for them. But on the other hand, I don’t recommend it for a man who’s using only one protective pad
a day. It’s all about expectations.

And expectations for penile implants – any words for that in terms of what patients sort of expect with an implant –
for the inflatable penile prosthesis?

So I think from a penile prosthetic point of view, you’ve got to understand it’s for function; it’s not for length. There
are red flags we all recognize. And so those things make you recognize it’s for the patient who’s doing it for the
right reasons. So if it’s for a functional impairment, that’s really what we’re getting at.

Any particular reason why you recommend the Coloplast Titan over the other available implants on the market?

You know, I’ve kind of grown up in the world of implants. I trained with Dr. Mulcahey, and I’ve been doing this 22
years. And I think that this is the implanter’s implant. It gives better girth. It gives better length. It’s just a better
device. I’ve had extensive surgical experience with both, and this is what I use exclusively.

I want to thank our panel for your time and your expertise in this area. We’d also like to thank Coloplast for
sponsoring this Webcast and offering these surgical instruments to patients who are in severe bother by
incontinence and erectile dysfunction. Thanks for watching our program on The Simultaneous Placement of the Titan Inflatable Penile Prosthesis and Virtue Male Urethral Sling.
Have a good day.