A simplified method of sizing testicular prosthesis

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BACKGROUND

Since 1941 implantation of testicular prosthesis has become an established therapeutic approach for patients with absent testes.^{1,2} The two UK companies that manufacture the large majority of implants used in the UK (Nagor, Douglas, Isle of Man, and Mentor, Wantage, Oxfordshire) offer sizing that range from small (10–12cm³) to large (17–19cm³).² With the current pressures on the National Health Service (NHS), we present a novel, cost effective technique for intraoperative selection of an appropriately sized testicular prosthesis.

TECHNIQUE

A low inguinal approach is favoured as it is associated with a lower risk of infection and extrusion.² In order to estimate the correct volume of implant needed, a 10cm × 10cm piece of gauze (Clinisupplies, Harrow, UK) is packed tightly into a 20ml syringe (B Braun, Bethlehem, PA, US), equivalent to 20cm³ in volume (Fig 1). After dissection of an appropriate sized pocket, the gauze is packed into the surgical cavity, to mimic the testicular prosthesis. The most appropriately sized prosthesis is then selected and secured in the hemiscrotum with a PDS® suture (Ethicon, Somerville, NJ, US) placed through its suture loop.

DISCUSSION

The loss or absence of a testicle poses traumatic psychological and aesthetic consequences, for which the use of a testicular prosthesis

Figure 1 A 10cm × 10cm piece of gauze packed into a 20ml syringe to estimate the volume of the prosthesis required for a bilateral testicular implant insertion for bilateral anorchia

can significantly improve quality of life.^{3,4} Given the financial constraints of the NHS, this is a simple and cost effective technique. It has previously been described by our group for the sizing of breast implants and it can be adapted easily to different volumes by altering the size of swab or syringe.⁵

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Transhernial laparoscopy in strangulated groin and ventral hernias

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BACKGROUND

Following emergency repair of clinically strangulated abdominal hernias, it is important to inspect the hernia contents to exclude compromised bowel and preoperative reduction-en-masse, which risks perforation and stricture.^{1,2} Visualisation is achieved by opening the hernia sac in the first instance. If the contents cannot be visualised adequately, it is common to proceed to laparotomy or laparoscopy.

TECHNIQUE

If there is doubt on the viability of reduced bowel, we recommend inserting a laparoscopic port through the hernia neck. We use a blunt trocar and a balloon port, which allows pneumoperitoneum. The patient should be tilted appropriately to move viscera away from the hernia. Reduced hernia contents tend to lie on the surface of the abdominal contents. If required, a further 5mm port can be inserted through an incision in the abdominal wall to aid examination of the bowel. We have used this technique successfully for femoral, inguinal and periumbilical hernias, avoiding larger incisions.

DISCUSSION

Using the neck of a hernia for insertion of a laparoscopic port is quick and avoids complications of further incisions. If there is no indication for further surgery, the port may be removed and the hernia repaired appropriately.