A simplified method of sizing testicular prosthesis

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doi 10.1308/rcsann.2016.0013

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

References

1. Turek PJ, Master VA. Safety and effectiveness of a new saline filled testicular prosthesis. *J Urol* 2004; **172**: 1,427–1,430.
2. Bodiwala D, Summerton DJ, Terry TR. Testicular prostheses: development and modern usage. *Ann R Coll Surg Engl* 2007; **89**: 349–353.
3. Yossepowitch O, Aviv D, Wainchwaig L, Baniel J. Testicular prostheses for testis cancer survivors: patient perspectives and predictors of long-term satisfaction. *J Urol* 2011; **186**: 2,249–2,252.
4. Adsheed J, Khoubehi B, Wood J, Rustin G. Testicular implants and patient satisfaction: a questionnaire-based study of men after orchidectomy for testicular cancer. *BJU Int* 2001; **88**: 559–562.
5. Caulfield RH, Niranjana NS. Innovative techniques: A novel technique for the intraoperative estimation of breast implant size in aesthetic and reconstructive breast surgery. *Aesthetic Plast Surg* 2008; **32**: 126–129.

Transhernial laparoscopy in strangulated groin and ventral hernias

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doi 10.1308/rcsann.2016.0016

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.

References

1. Sargent PW. Intestinal obstruction due to fibrous stricture consequent upon strangulated hernia. *Ann Surg* 1904; **39**: 733–742.
2. Watanobe I, Yoshida N, Watanabe S *et al*. Late-onset bowel strangulation due to reduction en masse of inguinal hernia. *Case Rep Surg* 2014; 295686.

The modified spacer for first stage revision hip arthroplasty

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doi 10.1308/rcsann.2016.0015

BACKGROUND

Periprosthetic infection following total hip arthroplasty usually necessitates a single or two-stage revision procedure. Loose cement should be removed but removal of well fixed cement risks complications¹ and can potentially be left.² When adopting a two-stage strategy, either an excision arthroplasty is performed or following debridement, an antibiotic impregnated spacer is implanted. Cement spacers may fracture (Fig 1), resulting in limb shortening and a less functional joint. We describe a simple technique that strengthens the spacer, thereby preventing fracture.

Figure 1 A broken antibiotic impregnated cement spacer

Figure 2 Preparation of a modified hip spacer with an Exeter™ stem cemented into a spacer mould that has had the stem part removed

Figure 3 Examples of modified hip spacers: Thompson hemiarthroplasty prosthesis (A), and Exeter™ head and stem (B)

TECHNIQUE

Remove the femoral and acetabular implants, debride, and then determine the acetabular and femoral canal diameters. The appropriately sized preshaped mould (Biomet, Warsaw, IN, US) is subsequently chosen and cut. Following injection of cement into the head part of the mould, the arthroplasty is placed into its centre (Fig 2). If the canal diameter is 12mm or greater, the cheaper, 40mm Thompson hemiarthroplasty prosthesis (Stryker, Kalamazoo, MI, US) is chosen; however, if the canal is narrow, an Exeter™ universal stem (Stryker) with a metal head can be chosen (Fig 3). After cement hardening, this construct can be cemented loosely into the femoral canal so as to allow elucidation of impregnated antibiotics but also easy extraction at the second stage of the revision. Cement should fully cover the prosthesis.

DISCUSSION

We have found the modified hip spacer to be very useful when a two-stage revision with a spacer is required. It aids infection eradication, permits movement, maintains limb length and resists fracture.