Surgical management of sexual dysfunction in men and women


Penile length lost to underlying disease cannot be reclaimed
Indentation deformities cannot be corrected
Advantages: local anesthetic, no risk of de novo ED, longitudinal incision (uncircumcised patients wishing to retain prepuce)
Pharmacologic erection rather than with saline infusion to view the full proximal extent of the curvature

Dorsal curvature - ventral longitudinal incision
Ventral curvature - fully expose dorsal neurovascular bundle - hemostat clamp used to create space (dot) between deep dorsal vein and paired dorsal arteries for the placement of sutures
Tunica cleaned, center of the curve is marked, dots are marked (reposition of dots and many fine adjustments EASILY MADE)

Each set of 4 dots consist of: in-out (1 cm); travel (at least 1 cm but can be much longer); in-out (1 cm) - avoid making dots too close to each other
For more acute/longer curves, best to have long travel: longer lever-arm and less tension as the suture is tied down
The sutures are placed and the first throw of a "surgeon's knot" is made
Sutures: soft, braided permanent material - 2-0 Ticron or Tevdek

Enough tension placed to straighten curvature; clamp with a "shod" placed at half-knot to hold it in position - to allow fine adjustments to be made once all sutures are satisfactorily in place
Once all shodded-clamps have been placed, erect penis is inspected from all angles for good alignment; adjustments to the tension of the sutures are made if needed
A smooth clamp is placed under each half-knot to prevent overtightening, and the remaining four knots are thrown
Once penis is straight, all knots are tied, a 21-gauge scalp needle is introduced into one of the corpora to evacuate blood, phenylephrine is introduced, in 500 microgram aliquots, to detumesce erection.

Hole from scalp needle closed using 5-0 Maxon or suture equivalent.

Wound irrigated, closed in two layers, the first with 5-0 Maxon and the skin with 5-0 Dexon or equivalent.

A good dressing to prevent postoperative edema and ecchymoses.

Petroleum-soaked gauze strip placed over incision, gauze sponge folded into strip and wrapped gently around the penis.

Coban or another self-adhesive compression dressing is wrapped from just under the corona down to the base of the penis.

Try for all penile skin to be incorporated; dressing should be snug but not tight.

Retract the foreskin and include it in the compression dressing (prevent paraphimosis).

Postoperative care: ice-packs, RTO 1st postoperative day to review instructions and show patient how to change dressing daily for 5 days.
Caveats For The Modeling Procedure

Recommended Cylinders: AMS CX & Mentor Titan
Mentor Had Better Mechanical Survival After Modeling
Paralyn Coating (2001) On AMS - May Have Stopped Damage
If Modeling Not Sufficient, Corporoplasty Short Side
Cover All Gaps w/ Mentor, Large Gaps w/ AMS

Wilson, Delk: J Urol 2001

Intralesional injection procedure

Irwin Goldstein MD
Director, Sexual Medicine, Alvarado Hospital
Clinical Professor of Surgery
University of California at San Diego
Director, San Diego Sexual Medicine
San Diego, California
Editor-in-Chief, The Journal of Sexual Medicine

Caveats On Modeling Procedure For Peyronie's Disease
Urethral Injury at Meatus 4%
Corporal Rupture Distally 1%
Straightening & Girth Improves With Usage

Wilson, Delk: J Urol 152:1121, 1994
Wilson, Delk: J Urol 165:825, 2001


Damage Outer Layer of Silicone By Modeling
Corporoplasty On Short Side if Insufficient Straightening

Irwin Goldstein MD
Director, Sexual Medicine, Alvarado Hospital
Clinical Professor of Surgery
University of California at San Diego
Director, San Diego Sexual Medicine
San Diego, California
Editor-in-Chief, The Journal of Sexual Medicine

www.sandiegosexualmedicine.com

Distal Shunt procedures

Lue, TF and Pescatore, E: Surgical Techniques - Distal Cavernosum-Glans Shunts for Ischemic Priapism J. Sex. Med. 3 (4) 2006
Frenular Graft procedure

Irwin Goldstein MD
Director, Sexual Medicine, Alvarado Hospital
Clinical Professor of Surgery
University of California at San Diego
Director, San Diego Sexual Medicine
San Diego, California
Editor-in-Chief, The Journal of Sexual Medicine

Hidden Penis procedure

Irwin Goldstein MD
Director, Sexual Medicine, Alvarado Hospital
Clinical Professor of Surgery
University of California at San Diego
Director, San Diego Sexual Medicine
San Diego, California
Editor-in-Chief, The Journal of Sexual Medicine
Torsion of the penis is a condition in which the penis rotates along its longitudinal axis, clockwise or anticlockwise. While this condition poses no functional limitations, it can be cosmetically unappealing. Torsion may be congenital or iatrogenic, a common complication of hypospadias repair. Surgical correction is through counter-rotation by a dorsal, proximally-based Dartos flap that is rotated in the same direction to which the penis is torted, and is sutured distally to the lateral aspect of the penis. Step 1 shows pre-operative appearance with an evident clockwise rotation.

Step 2: A dorsal subcoronal semi-circular incision is cut. A plane of dissection is developed between the skin and Dartos superficially. In most cases, there is an avascular track between the skin and Dartos, that can be pursued by blunt dissection for this purpose. Care must be taken not to deprive the skin of its blood supply. The superficial plane should extend down to the base of the penis. Another plane is created between Dartos and Buck’s fascia. Meticulous dissection and the application of optical magnification and trans-illumination can help preserve the vascular supply of the flap, with direct impact on the sustainability of the results of surgery. The deeper plane should not extend down to the base of the penis. The deeper plane is deepened as much as is needed for convenient rotation of the flap, while keeping it taught enough to achieve counter-rotation.

Step 3: The deeper flap is rotated in the same direction of torsion (clockwise in the case at hand) and its tip is sutured to the distal aspect of the tunica albuginea using slowly absorbable sutures. Multiple sutures are placed on multiple levels to provide backups in case one point of attachment snaps. Sutures should be placed through the deep surface of the flap, not spanning its whole thickness, to avoid ischemic necrosis and therefore separation of the point of attachment.
Step 4: The resulting counter-rotation is assessed and is fine-tuned by plication of the distal border of the flap for more counter-rotation, or further release of this border from the base of the penis for less counter-rotation. After full correction, the wound is closed with subcuticular absorbable sutures, through which two to three interrupted sutures are placed to avoid dehiscence upon erection. Average operative time for the procedure is 30 minutes. Patients can be discharged in the same day and can return to work the next morning.

Subcutaneous Testosterone Pellet procedure


Finger Sweep and Mummy Wrap procedure


Irwin Goldstein MD
Director, Sexual Medicine, Alvarado Hospital
Clinical Professor of Surgery
University of California at San Diego
Director, San Diego Sexual Medicine
San Diego, California
Editor-in-Chief, The Journal of Sexual Medicine

Miminally Invasive Penile Implant procedure

Irwin Goldstein MD
Director, Sexual Medicine, Alvarado Hospital
Clinical Professor of Surgery
University of California at San Diego
Director, San Diego Sexual Medicine
San Diego, California
Editor-in-Chief, The Journal of Sexual Medicine

Irwin Goldstein MD
Director, Sexual Medicine, Alvarado Hospital
Clinical Professor of Surgery
University of California at San Diego
Director, San Diego Sexual Medicine
San Diego, California
Editor-in-Chief, The Journal of Sexual Medicine

Malpositioned Penile Implant procedure

Dorsal Slit procedure

Irwin Goldstein MD
Director, Sexual Medicine, Alvarado Hospital
Clinical Professor of Surgery
University of California at San Diego
Director, San Diego Sexual Medicine
San Diego, California
Editor-in-Chief, The Journal of Sexual Medicine

Bartholin’s Cyst Marsupialization procedure