

and is palpable beneath the skin. Clotted blood is extracted by squeezing the penis until the penis is flaccid.

CONCLUSIONS: This anatomically accurate model allows urology residents to practice several treatments for priapism before encountering this urologic emergency on actual patients.

Source of Funding: None

V10-04

A MODIFIED TECHNIQUE FOR DOUBLE DISTAL CORPORAL ANCHORING STITCH IN THE MANAGEMENT OF LATERAL PENILE PROSTHESIS CYLINDER EXTRUSION

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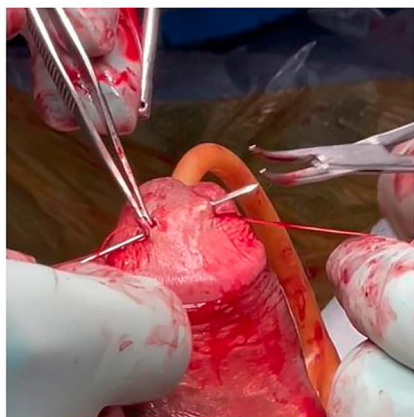
INTRODUCTION AND OBJECTIVE: Distal extrusion, or impending erosion, is a notable complication following inflatable penile prosthesis (IPP) surgery. Prompt intervention is crucial to avert further erosion, infection, and potential removal of the device. Several techniques have been applied to manage distal cylinder extrusion, including corporal repair with synthetic or biological grafts, distal corporoplasty, and distal corporal anchoring stitches. The standard anchoring technique requires a glans incision to secure the cylinder tips with sutures. This video presents a modified double distal anchoring corporal stitch technique that eliminates the need for a glans incision, used alongside plaque incision and grafting with a slicing technique to treat post-IPP penile curvature and bilateral cylinder extrusion.

METHODS: A 66-year-old male with a history of prostate cancer treated with brachytherapy presented six weeks post IPP surgery with new penile curvature and bilateral distal cylinder extrusion. Despite initially attempting to use the device, painful intercourse led to a decision for surgical repair. To correct the curvature, a plaque incision and grafting were performed, while the cylinder extrusion was addressed with a modified distal corporal anchoring stitch that tunneled the threads under the glans skin, avoiding a glans incision (image 1).

RESULTS: The patient had an uneventful postoperative course. At the three and five-month follow-up, he reported optimal device function without any complications, with correction of penile curvature and a straightened shaft. The cylinder tips were correctly positioned at the mid-glans level, with minimal scarring and an aesthetically pleasing outcome that significantly enhanced his satisfaction with the procedure.

CONCLUSIONS: Distal corporoplasty combined with modified bilateral anchoring corporal stitches is a reliable, effective and safe approach for managing distal lateral cylinder extrusion. This modified technique, which avoids a glans incision, offers a less invasive, quicker, and potentially less painful approach with improved cosmetic outcomes compared to the standard technique.

Image 1: Distal anchoring stitch technique with tunneling of the cylinder threads under the skin to avoid glans incision.



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V10-05

MANAGEMENT OF REFRACTORY PENILE PROSTHETIC INFECTION: CARRION CAST

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INTRODUCTION AND OBJECTIVE: Welcome to a video demonstration of the management of refractory penile prosthetic infection with the Carrion Cast by Dr. Falasiri, Drs. Garrigan, Parker, Fernandez-Crespo, and Carrion from the University of South Florida Department of urologic surgery. In this video, we'll discuss the surgical technique of placing a Stimulan (that is, a calcium sulfate) cast, (colloquially known as the Carrion cast) in patients presenting with a penile prosthetic infection. Typically, the patients in which this is considered are those that present with recurrent and refractory prosthetic infections despite salvage placement of a new implant, those with prior infections with MDR organisms, or in those whom salvage placement of a new implant is not feasible.

METHODS: Initially, a 14G angiocatheter was used for injecting solutions into the corpora. Now, alternative methods like a Toomey syringe and large-bore catheters ensure complete proximal filling, while pellet-like implants are created using chest tube molds. This video showcases the Carrion cast placement with the pellet implant method. The patient presented has a complex penile prosthesis history, initially receiving an IPP at 45, followed by a revision at another facility. Later, he developed an infection and underwent IPP removal and SRPP salvage. After several subsequent complications and infections, he agreed to the Carrion cast procedure and a delayed reimplantation in 6–8 weeks. The setup includes two 36 Fr chest tubes cut into 4cm segments, Vancomycin 1000mg, and Tobramycin 1200mg powders. The chest tubes act as molds, shaping pellets for corpora and penoscrotal spaces, which maintain space and allow antibiotic diffusion. Tube size can be modified to suit patient girth, with variable setting times for different antibiotics. Calcium sulfate powder is available in 5, 10, or 20mL packets and is mixed with antibiotic powder to form a paste, avoiding clumps that could delay setting. Water is added if using powder-based antibiotics. The paste is molded to form uniform beads, ensuring complete filling to maximize coverage within the infected pump's scrotal area. Pellets are then spread evenly in the penoscrotal space for broad antibiotic distribution. For larger implants, the thick calcium sulfate mixture fills the 4cm chest tubes. After solidifying, the pellets are extracted and placed both proximally and distally within the corpora. A watertight closure of corporotomies completes the procedure.

RESULTS: Four patients underwent treatment utilizing the Carrion Cast method for refractory penile prosthetic infection. Patients underwent removal of infected penile prostheses followed by placement of calcium sulfate antibiotic casts (Stimulan) infused with vancomycin and tobramycin. Following treatment with the Carrion cast, patients were successfully reimplanted with penile prostheses at intervals ranging from 25 days to 3 months post-cast placement. All patients had a history of multiple prior penile prosthetic surgeries, with at least one previous infection prior to cast placement. Post-procedure, no immediate complications or recurrent infections were observed, demonstrating effectiveness in managing complex and refractory penile prosthetic infections.

CONCLUSIONS: The Carrion cast, utilizing antibiotic-impregnated calcium sulfate pellets, represents an effective technique for managing refractory penile prosthetic infections. This approach facilitates successful subsequent prosthesis reimplantation in challenging cases, indicating its value as an interim management strategy for patients with recurrent, refractory, or complex penile prosthetic infections. Further research is recommended to optimize antibiotic combinations and timing for reimplantation.

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