

## Editorial Commentary

### Outpatient surgery for penile venous patch with the patient under local anesthesia

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Hsu G-L, Hsieh C-H, Wen H-S, Hsieh J-T, Chiang H-S. Outpatient surgery for penile venous patch with the patient under local anesthesia. *J Androl.* 2003;24:35-39. [[Abstract/Free Full Text](#)]

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The paper by Hsu et al describes a novel approach to plaque incision and grafting surgery; that is, the use of local anesthesia. The authors describe in intricate detail the technique for administering a local anesthetic agent, which essentially involves subpubic infiltration and a circumferential penile block. As with other forms of penile surgery including penile prosthetic surgery, there has been a shift from inpatient to outpatient surgery, and a toward the use of regional or local anesthesia. The acceptance of less-invasive techniques, however, must be predicated on proving that the outcomes in efficacy and adverse event profile are similar to outcomes using standard approaches.

The therapeutic outcomes from Peyronie disease surgery are dependent on preoperative curvature, preoperative erectile function, and preoperative length. The authors have a series of 29 patients who had excellent erectile function preoperatively, which is preserved following the procedure using a validated instrument. The preoperative curvature ranged from 30° to 90° preoperatively (no mean value was noted) and 93% of patients had minimal residual curvature postoperatively; unfortunately, although of great importance to postoperative patient satisfaction, no assessment of erect penile length was performed. Thus, in keeping with much of the literature, the authors' approach to plaque incision and grafting appears to be effective with a minimal adverse event profile.

Our center performs formal plaque incision and grafting (using the Lue technique) on an outpatient basis, and 100% of our patients have left the hospital within 4 hours of surgery. Our patients have their penis infiltrated with local anesthetic at the end of the procedure and they use postoperative oral narcotic analgesics. From a technical point, we never use epinephrine in our local anesthetic solutions for penile surgery because of the concern for tissue ischemia. However, Levine et al clearly indicate there was no such complication in their series. Surgeons who try this should pay

strict attention not only to the total dose of local anesthetic agent but to the mg/kg dose as well. We routinely use an operating microscope for neurovascular bundle identification and have negligible magnification for this portion of the procedure. Furthermore, the deep dorsal vein is tethered in place by a series of venous communications that can cause problematic bleeding if not addressed properly, and magnification facilitates their control. The authors fail to mention postoperative penile sensation assessment, which also directly reflects patient satisfaction.

It has been my experience that the deep dorsal vein does not offer a large enough surface area to graft onto the gap that is present after plaque incision, which thus prompts the use of the saphenous vein by some authorities. The authors circumvent this problem by making a small transverse incision in the plaque, which leaves a smaller gap than that which occurs after an H-type (Lue) incision. This small incision is reflected in the need for corporal counterincisions in a significant number (11 of 29) of the authors' patients. The preoperative identification of the deep dorsal vein using a cavernosography is probably unnecessary because the deep dorsal vein is a highly consistent anatomic structure, and even in its absence, other local veins may be available for use. If preoperative mapping is required, the use of Duplex penile ultrasound could supplant cavernosography, which although it is safe, exposes the patient to contrast agent and intracorporal needle placement.

Although the authors used a validated erectile function assessment tool, which demonstrated no change in the mean postoperative scores, this does not mean that individual patients may not experience alterations that may negatively affect their postoperative satisfaction. Indeed, in this series, one patient needed a penile implant and two failed to have restoration of erectile function until 10 months after surgery. In summary, this work confirms the utility of plaque incision and grafting in the surgical management of Peyronie disease. It introduces the concept of local anesthesia for this operation and demonstrates that this approach is viable. Whereas the authors suggest that this approach is cost-effective, a formal cost analysis will be required in the future to prove this.

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