



◀ Fig. 24.1a–e. Methods for protective intermediate layer

the junction of the tunica vaginalis and epididymis, and the testicle is brought forth. Traction sutures are placed on the lateral edges of the tunica vaginalis, and incisions are made a few millimeters from the edge of the epididymis on either side. Proximal to the testicle, a transverse incision through the tunica vaginalis only is then made. This is similar to the dissection of the processus vaginalis from the spermatic cord during an orchiopexy at the proximal end of the spermatic cord. In some cases, the tunica vaginalis is generous and easily covers the penis without separating additional tunica vaginalis from the spermatic cord. In this situation, incisions parallel to the spermatic cord suffice. In the usual circumstance, with the proximal transverse tunica vaginalis incision made, careful dissection elevates the tunica vaginalis from the spermatic cord. This dissection is carried out parallel to the spermatic cord toward the superficial inguinal ring as far as vision and retraction allow, taking care to leave all of the surrounding tissue and cremaster fibers with the pedicle to ensure its rich blood supply. Length of the pedicle is seldom a problem, and extensive dissection is not regularly needed. As elevation of the tunica vaginalis takes place, the spermatic cord often seems to emanate from a sleeve of this pedicle. To allow the testicle to be replaced in the scrotum, the lateral margin of this sleeve may need a longitudinal incision to allow the tunica

vaginalis to move medially and the testicle and spermatic cord to fall laterally. The incision is made laterally to preserve as much blood supply to the pedicle of the tunica vaginalis as possible. Once the dissection is completed, haemostasis is obtained with the electrocautery and the testicle is replaced into the scrotum in its natural position.

With the neourethra in place, the penis is ready to be covered with the tunica vaginalis like a blanket. It has not made a difference which side of the tunica vaginalis is placed toward the neourethra, and we prefer to place the shiny visceral surface toward the neourethra. Fine absorbable sutures are used longitudinally to suture the tunica vaginalis parallel and lateral to the dorsal neurovascular bundle. The flap, now sutured into place on the lateral aspect of the penis, is drawn across the ventral aspect of the penis to the other side, and a matching longitudinal closure is accomplished. This blankets the neourethra. If a glans-tunneling technique was used during the hypospadias repair, the tunica vaginalis may be passed distally through the glans channel with the neourethra or it may be tacked as far into the glans channel as possible, because coronal fistulas are among the most common that develop. If the neourethra has a pedicle, care should be taken not to confine the pedicle too tightly. It is seldom a problem. When this step is completed, the penis is



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