ATOMS Male Sphincter

**Item Number:** 37381, 37387, 36812

Why is it done?

 Male Stress incontinence/ Incontinence

 Usually after a TURP/TUVP, Radical Prostatectomy in 2% of cases as pre-described complication of surgery

**Pre-requirements**

 An informed consent is required from the patient and a pre-admission clinic will be arranged.

 Patients may not eat or drink from midnight the previous evening.

 Patients are to refrain from smoking before the procedure.

 **Patients allergic to IODINE/CHLORHEXIDINE should clearly state this at the pre-admission clinic as well as to theatre staff and Dr Schoeman.**

 Any anti-coagulants such as Warfarin or Aspirin must be stopped 7 days prior to surgery. This may be replaced by once daily Clexane injections.

 Pre-operative blood tests are required 4 days prior to surgery.

 Patients with cardiac illnesses require a cardiologist/ physician report.

 A chest X-ray is required for patients with lung disease.

 Be prepared for a 2 night stay.

 

How is it done?

 Anaesthetic, as decided by the anaesthetist.

 The legs will be elevated into the lithotomy position.

 A 7cm incision is made on the perineum (space between scrotum and anus).

 The silicone inflatable cushion is placed anterior to the upper end of the corpora cavernosa of the penis.

 The arms of the device are curled around the inferior rami of the pubic bone.

 The device is placed with pressure on the CC

 This tensioning can be done under cystoscopic vision.

 The access port is placed in the scrotum

 The pad is inflated with carefully determined volume

 The wounds are closed with dissolvable sutures and/or skin glue.

 A local anaesthetic is given for pain relief.

 A urinary catheter is placed for 24hrs.

 The catheter will be removed early the next morning.

 The patient’s urine output will be measured each time they urinate and the residual will be measured. (Patients will be required to do this up to 3 times.)

 If the residual amount of urine is more than 1/3 of the total bladder capacity, the patient may have to self-catheterize, until the residual volume is acceptable.

 Prophylactic antibiotics will be given to prevent infection.

******

Complications

 Any anaesthetic has its risks and the anaesthetist will explain all such risks.

 Complications: hemorrhaging, requiring blood transfusion <1%;

 Patients will wake up with a catheter in the urethra and bladder. This will remain in the bladder for 24 hrs.

 Pelvic pain for 10-14 days may occur, making it difficult to sit.

 If you cannot urinate after 2-3 attempts, the catheter may be replaced and adjustment to sphincter volume will be made

 This may less effective in irradiated patients

 NB! Each person is unique and for this reason symptoms may vary!

.

  

**What next?**

 Patients will have a trial of void without catheter the next day.

 Patients will be discharged as soon as they can completely empty the bladder.

 Adjustments to sphincter pad volumes will be made in 6 weeks.

 Patients may initially suffer from urge incontinence but this will improve within the next 6 weeks.

 Allow 6 weeks for symptoms to stabilise.

 Initial period of pelvic pain is expected.

 

Copyright 2019 Dr Jo Schoeman