Smartphrases

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

LJNEW

Referring provider: **@REFPROV@**

**Chief Complaint**

\*\*\*

**HPI**

Mr. @LNAME@ is a @AGE@ male with history of \*\*\* who presents with \*\*\*.

Race/Ethnicity: {Desc; Race/Ethnicity:17218}

Gender identity: {LJ Gender Identity:20716}

Sexual orientation: {LJ Sexual orientation:20715}

Marital status: {MARITAL STATUS:21291}

Partner's first name: \*\*\*

Partner's age: \*\*\*

Duration of relationship: \*\*\* years

Relationship quality: "\*\*\*"

Sexual relationship quality: "\*\*\*"

Partner Present today: {YES (DEF) /NO:19695::"No"}

His partner {Does/does not:20985} contribute to his sexual dysfunction. His partner {HAS HAS NOT:19958} expressed interest in having his sexual problems treated.

@REVFS(676)@

Low testosterone symptoms

Duration of symptoms: \*\*\*

In the past, he has used: \*\*\*

Started therapy: \*\*\*

Interest in future fertility? {YES (DEF) /NO:19695::"No"}

Mood swings? {YES (DEF) /NO:19695::"No"}

Low energy? {YES (DEF) /NO:19695::"Yes"}

Afternoon fatigue? {YES (DEF) /NO:19695::"Yes"}

Reduced strength? {YES (DEF) /NO:19695::"Yes"}

Reduced work productivity? {YES (DEF) /NO:19695::"Yes"}

Reduced endurance? {YES (DEF) /NO:19695::"Yes"}

Muscle mass loss? {YES (DEF) /NO:19695::"Yes"}

Fat gain? {YES (DEF) /NO:19695::"Yes"}

Irritability? {YES (DEF) /NO:19695::"Yes"}

Depression symptoms? {YES (DEF) /NO:19695::"Yes"}

Confusion or short term memory loss? {YES (DEF) /NO:19695::"Yes"}

Sexual Function

Interest in sexual relations: \*\*\* Sexual desire/Libido: \*\*\*/10

Onset of sexual dysfunction: \*\*\*ago And was sudden\*\*\*gradual

Before the problem, intercourse frequency: \*\*\*

Currently, intercourse frequency: \*\*\*

Masturbation frequency: \*\*\*

Lubricant used with masturbation: {Yes\_No\_N/A:21248}

Percent of the time able to penetrate: \*\*\*%

Loses erections prior to penetration: {Yes\_No\_N/A:21248}

Loses erections during intercourse: {Yes\_No\_N/A:21248}

Penile length loss: Erect {Yes\_No\_N/A:21248}

Flaccid {Yes\_No\_N/A:21248}

Penile deformity History

Onset/duration: \*\*\*

Last change in curvature: \*\*\*

Presenting symptom: \*\*\*pain\*\*\*deformity\*\*\*nodule

Pain with erections: {Yes\_No\_N/A:21248}

Pain with intercourse: {Yes\_No\_N/A:21248}

Pain when flaccid: {Yes\_No\_N/A:21248}

History of trauma: {YES(DEF)/NO:22152}

History of Dupuytren's {YES(DEF)/NO:22152}

History of Congenital curve {YES(DEF)/NO:22152}

Prior/current treatments: {YES(DEF)/NO:22152}

Bother: {MILD, MODERATE, SEVERE ED:22334}

Partner Bother: {MILD, MODERATE, SEVERE ED:22334}

Impairment: {MILD, MODERATE, SEVERE ED:22334}

Primary deformity: \*\*\*

Secondary deformity: \*\*\*

Difficulty with penetration: \*\*\*

Patient Goals: \*\*\*

He primarily has difficulty with achieving \*\*\* maintaining an erection.

**Without medication with a partner**, he rates his erectile rigidity as a **\*\*\*** on a scale of 0-10 (with 6 being just firm enough for penetration).

**Without medication with masturbation**, he rates his erectile rigidity as a **\*\*\*** on a scale of 0-10 (with 6 being just firm enough for penetration).

**At night / upon awakening**, he rates his erectile rigidity as a **\*\*\*** on a scale of 0-10 (with 6 being just firm enough for penetration).

Orgasm present: {Yes\_No\_N/A:21248::"Yes"}

Orgasmic Pain: {Yes\_No\_N/A:21248::"No"}

IELT: \*\*\* mins

Premature Ejaculation: {Yes\_No\_N/A:21248::"No"}

Duration: \*\*\*

Control: {GOOD FAIR POOR:100023785}

Bother: {MILD, MODERATE, SEVERE ED:22334}

Partner Bother: {MILD, MODERATE, SEVERE ED:22334}

He has tried **\*\*\*** in the past with un \*\*\* satisfactory results.

**With \*\*\***, he rates his erectile rigidity as a **\*\*\*** on a scale of 0-10 (with 6 being just firm enough for penetration).

He **{Does/does not:20985}** take the oral PDE5- on an empty stomach, 1 hour prior to intercourse and without alcohol.

He **{Does/does not:20985::"does not"}** take oral nitrates for chest pain.

**Past Medical History**

@PMH@

**Past Surgical History**

@PSH@

**Medications**

@CMED@

**Allergies**

@ALLERGY@

**Social History**

@SOCHX@

**Family History**

@FAMHX@

**Review of Systems**

Complete ROS was queried, reviewed and has been scanned into IHIS.  Pertinent findings are included in the interval history.

**Physical Exam**

@VS@

@BMI@

Constitutional: He is well-developed, well-nourished, and in no distress.

Neurological: He is alert and oriented to person, place, and time.

Psychiatric: Mood and affect normal.

HEENT: Normocephalic and atraumatic. Conjunctivae normal. Oropharynx is clear and moist. Neck supple.

Lymphadenopathy: He has no cervical, supraclavicular, or inguinal adenopathy.

Cardiovascular: normal peripheral perfusion

Pulmonary/Chest: Respirations are even and non-labored. No respiratory distress.

Abdominal: Soft. He exhibits no distension, no ascites and no mass. There is no tenderness. No hernia.   
Neurological: A + O. Cranial Nerves II-XII grossly intact. Normal gait.

Extremities: MOE, Warm. No clubbing. No cyanosis.

Skin: Skin is warm and dry. No lesion and no rash noted.

**Genitourinary**

Penis: {Desc; circumcised/uncircumcised:5705::"circumcised"} penis, glans normal, no penile discharge. No rashes/lesions. Penile stretch: {NORMAL/ABNORMAL:23458::"Normal"} {GOOD FAIR POOR:100023785::"Good"}. Penile plaque: {NORMAL/ABNORMAL:23458::"Normal"}

Testes: Left: **\*\*\***mL, Right: **\*\*\***mL, no masses and normal consistency, {Desc; tender/non:10087::"nontender"} to palpation. Vasa palpable bilaterally. **\*\*\*** clinically palpable varicocele with valsalva. Epididymis: {NORMAL/ABNORMAL:23458::"Normal"}, Remainder of scrotal contents normal

Perineum: No perineal pain with palpation

Rectal: Normal tone, no masses

Prostate: {NUMBERS; 5-50 BY 5:60395} grams, symmetric, non-tender, anodular and no induration

**Labs**

@LASTLABX(TESTTOTBYLCM:10,TESTOSTERONE:10,TESTOSFREEDI:10,TESTOSTFR:10,SEXHORMBNDG:10,ESTRADIOLENH:10,PROLACTIN:10,FSH:10,LH:10,HCT:10,PSA:10,)@

@LASTLABOSUSHORT(HGBA1C)@

@LASTLABOSUSHORT(TSH,TSH15MIN,TSH30MIN,TSHBASELINE,TSHULTRASEN)@

@BRIEFLAB(CHOLESTEROL,CHOLESTEROLP,CHOLESTEPOCT,CHOLESTEROLC,TRIGLYCRIDE,TRIGLYCERIDES,TRIGLYCERIDT,HDL,HDLCHOLESTE,HDLPOINTOFCA,LDL,LDLCHOLCALC,DIRLDLCHOL,LDLDIRECTMEA,LDLPOINTOFCA,CHOLHDL,CHOLTOTALHDL)@

@FRAMASCVDRISK@

**Assessment/Plan**

Mr. @LNAME@ is a @AGE@ male with:

1. \*\*\*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

LJNEWINFERTILITY

Referring provider: **@REFPROV@**

**Chief Complaint**

\*\*\*

**HPI**

Mr. @LNAME@ is a @AGE@ male with history of \*\*\* who presents with \*\*\*.

Race/Ethnicity: {Desc; Race/Ethnicity:17218}

Gender identity: {LJ Gender Identity:20716}

Sexual orientation: {LJ Sexual orientation:20715}

Marital status: {MARITAL STATUS:21291}

Partner's name: \*\*\*

Partner's age: \*\*\*

Duration of relationship: \*\*\* years

Relationship quality: "\*\*\*"

Sexual relationship quality: "\*\*\*"

Partner Present today: {YES (DEF) /NO:19695::"No"}

@REVFS(676)@

Low testosterone symptoms

Duration of symptoms: \*\*\*

In the past, he has used: \*\*\*

Started therapy: \*\*\*

Interest in future fertility? {YES (DEF) /NO:19695::"No"}

Mood swings? {YES (DEF) /NO:19695::"No"}

Low energy? {YES (DEF) /NO:19695::"Yes"}

Afternoon fatigue? {YES (DEF) /NO:19695::"Yes"}

Reduced strength? {YES (DEF) /NO:19695::"Yes"}

Reduced work productivity? {YES (DEF) /NO:19695::"Yes"}

Reduced endurance? {YES (DEF) /NO:19695::"Yes"}

Muscle mass loss? {YES (DEF) /NO:19695::"Yes"}

Fat gain? {YES (DEF) /NO:19695::"Yes"}

Irritability? {YES (DEF) /NO:19695::"Yes"}

Depression symptoms? {YES (DEF) /NO:19695::"Yes"}

Confusion or short term memory loss? {YES (DEF) /NO:19695::"Yes"}

Fertility History

He and his partner have been attempting conception for **\*\*\*** months.

Ideally, they would like to have **\*\*\*** children.

Neither use birth control and they do not use commercial lubricants.

\*\*\*No other surgeries, h/o radiation or childhood illnesses.

His partner is **\*\*\*** years old and she **{has/has not:19958}** previously been pregnant.

She has **\*\*\*** chronic medical conditions.

She **{does/does not:20985}** have regular menses and she **{HAS HAS NOT:19958}** visited an OB/Gyn specifically to address fertility problems.

She **{has/has not:19958}** undergone a fertility work up.

Fertility-related ROS: refer to patient history form

Sexual Function

Sexual desire/Libido: \*\*\*/10

Currently, intercourse frequency: \*\*\*

Masturbation frequency: \*\*\*

Loses erections during intercourse: {Yes\_No\_N/A:21248}

**Without medication with a partner**, he rates his erectile rigidity as a **\*\*\*** on a scale of 0-10 (with 6 being just firm enough for penetration).

Orgasm present: {YES (DEF) /NO:19695::"Yes"}

IELT: \*\*\* min

Premature Ejaculation: {Yes\_No\_N/A:21248::"No"}

Duration: \*\*\*

Control: {GOOD FAIR POOR:100023785}

Bother: {MILD, MODERATE, SEVERE ED:22334}

Partner Bother: {MILD, MODERATE, SEVERE ED:22334}

**Past Medical History**

@PMH@

**Past Surgical History**

@PSH@

**Medications**

@CMED@

**Allergies**

@ALLERGY@

**Social History**

@SOCHX@

**Family History**

@FAMHX@

**Review of Systems**

Complete ROS was queried, reviewed and has been scanned into IHIS.  Pertinent findings are included in the interval history.

**Physical Exam**

@VS@

@BMI@

Constitutional: He is well-developed, well-nourished, and in no distress.

Neurological: He is alert and oriented to person, place, and time.

Psychiatric: Mood and affect normal.

HEENT: Normocephalic and atraumatic.. Conjunctivae normal. Oropharynx is clear and moist. Neck supple.

Lymphadenopathy: He has no cervical, supraclavicular, or inguinal adenopathy.

Cardiovascular: Regular rate and regular rhythm.

Pulmonary/Chest: Respirations are even and non-labored bilaterally. No respiratory distress.

Abdominal: Soft. Bowel sounds are normal. He exhibits no distension, no ascites and no mass. There is no tenderness. No hernia.   
Neurological: A + O. Cranial Nerves II-XII grossly intact. Normal gait.

Extremities: MOE, Warm. No clubbing. No cyanosis.

Skin: Skin is warm and dry. No lesion and no rash noted.

**Genitourinary**

Penis: {Desc; circumcised/uncircumcised:5705::"circumcised"} penis, glans normal, no penile discharge. No rashes/lesions. Penile stretch: {NORMAL/ABNORMAL:23458::"Normal"} {GOOD FAIR POOR:100023785::"Good"}. Penile plaque: {NORMAL/ABNORMAL:23458::"Normal"}

Testes: Left: **\*\*\***mL, Right: **\*\*\***mL, no masses and normal consistency, {Desc; tender/non:10087::"nontender"} to palpation. Vasa palpable bilaterally. **\*\*\*** clinically palpable varicocele with valsalva. Epididymis: {NORMAL/ABNORMAL:23458::"Normal"}, Remainder of scrotal contents normal

Perineum: No perineal pain with palpation

Rectal: Normal tone, no masses

Prostate: {NUMBERS; 5-50 BY 5:60395} grams, symmetric, non-tender, anodular and no induration

**Labs**

@LASTLABX(TESTTOTBYLCM:10,TESTOSTERONE:10,TESTOSFREEDI:10,TESTOSTFR:10,SEXHORMBNDG:10,ESTRADIOLENH:10,PROLACTIN:10,FSH:10,LH:10,HCT:10,PSA:10,)@

**Semen Analysis**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date | Volume | Conc | Motility | Fwd prog | Activity | Normal Morph | Absti | Post Wash TMC | comment |
|  |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

**Assessment/Plan**

Mr. @LNAME@ is a @AGE@ male with:

1. \*\*\*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

LJVASECTOMYCONSULT

Referring provider: **@REFPROV@**

**Chief Complaint**

Elective sterilization

**HPI**

Mr. @LNAME@ is a @AGE@ male who presents with desire for permanent, elective sterilization.

Race/Ethnicity: {Desc; Race/Ethnicity:17218}

Gender identity: {LJ Gender Identity:20716}

Sexual orientation: {LJ Sexual orientation:20715}

Marital status: {MARITAL STATUS:21291}

Partner's name: \*\*\*

Partner's age: \*\*\*

Duration of relationship: \*\*\* years

Relationship quality: "\*\*\*"

Partner Present today: {YES (DEF) /NO:19695::"No"}

He has \*\*\* children. (Ages: \*\*\*)

His wife/partner {IS/IS NOT:9024} supportive of this decision.

He has been considering this decision for \*\*\* year(s).

@REVFS(676)@

**Past Medical History**

@PMH@

**Past Surgical History**

@PSH@

**Medications**

@CMED@

**Allergies**

@ALLERGY@

**Social History**

@SOCHX@

**Family History**

@FAMHX@

**Review of Systems**

Complete ROS was queried, reviewed and has been scanned into IHIS.  Pertinent findings are included in the interval history.

**Physical Exam**

@VS@

@BMI@

Constitutional: He is well-developed, well-nourished, and in no distress.

Neurological: He is alert and oriented to person, place, and time.

Psychiatric: Mood and affect normal.

HEENT: Normocephalic and atraumatic.. Conjunctivae normal. Oropharynx is clear and moist. Neck supple.

Lymphadenopathy: He has no cervical, supraclavicular, or inguinal adenopathy.

Cardiovascular: Regular rate and regular rhythm.

Pulmonary/Chest: Respirations are even and non-labored bilaterally. No respiratory distress.

Abdominal: Soft. Bowel sounds are normal. He exhibits no distension, no ascites and no mass. There is no tenderness. No hernia.   
Neurological: A + O x 3. Cranial Nerves II-XII grossly intact. Normal gait.

Extremities: MOE x 4, Warm. No clubbing. No cyanosis.

Skin: Skin is warm and dry. No lesion and no rash noted.

**Genitourinary**

Penis: {Desc; circumcised/uncircumcised:5705::"circumcised"} penis, glans normal, no penile discharge. No rashes/lesions. Penile stretch: {NORMAL/ABNORMAL:23458::"Normal"} {GOOD FAIR POOR:100023785::"Good"}. Penile plaque: {NORMAL/ABNORMAL:23458::"Normal"}

Testes: Left: **\*\*\***mL, Right: **\*\*\***mL, no masses and normal consistency, {Desc; tender/non:10087::"nontender"} to palpation. **\*\*\*** clinically palpable varicocele with valsalva. Epididymis: {NORMAL/ABNORMAL:23458::"Normal"}, Remainder of scrotal contents normal. **Bilateral vasa palpable**

**Assessment and Plan**

Mr. @LNAME@ is a @AGE@ male who presents today requesting permanent, irreversible surgical sterilization. The vasectomy was discussed in detail with the patient today including the risks which are failure of the procedure, infection, bleeding, development of chronic testicular pain and the possibility of injuring adjacent structures which could potentially result in loss of the testicle. Furthermore, the patient was told he would remain fertile following the procedure until he provided a semen analysis that showed no sperm. The patient expressed understanding and desire to proceed. He will be scheduled for vasectomy at his convenience.

Counseled regarding:

-Permanence

-Reversal

-Sperm Banking

-Early Failure 1/1000

-Late Failure 1/4500

-Infection 1/1000

-Hematoma 1/1000

-Chronic Pain 1/500

I provided an Rx for Meloxicam prior to the procedure and the consent was signed today.

He was instructed to obtain a semen analysis 8 weeks after the vasectomy procedure.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

LJESTMALE

**CC**

\*\*\*

**HPI**

Mr. @LNAME@ is a @AGE@ male who returns with \*\*\*.

Interval History:\*\*\*

I have reviewed the patient's medical history in detail and updated the computerized patient record.

**Last visit \*\*\***

**Review of Systems**

Constitutional: Negative for fever, chills, weight loss, weight gain.

Cardiovascular: Negative for chest pain.

Respiratory: Negative for shortness of breath.

Gastrointestinal: Negative for nausea, abdominal pain, diarrhea, constipation.

**Past Medical History**

@PMH@

**Past Surgical History**

@PSH@

**Medications**

@CMED@

**Allergies**

@ALLERGY@

**Social History**

@SOCHX@

**Family History**

@FAMHX@

**Physical Exam**

@VS@

@BMI@

General appearance: {General:10016600}

Head: {Exam; head:18723}

Eyes: negative

Abdomen: {Exam; abdomen:10016834::"normal findings: no masses palpable, no organomegaly, soft, non-tender"}

Male genitalia: {Exam; male genitalia:1005789}

Extremities: {Exam; extremity:1005109}

Skin: {Skin exam-one line:18725}

Neurologic: {Exam; neuro:10017854}

**Diagnostic Tests**

@LASTLABX(TESTTOTBYLCM:10,TESTOSTERONE:10,TESTOSFREEDI:10,TESTOSTFR:10,SEXHORMBNDG:10,ESTRADIOLENH:10,PROLACTIN:10,FSH:10,LH:10,HCT:10,PSA:10,)@

@LASTLABOSUSHORT(HGBA1C)@

@LASTLABOSUSHORT(TSH,TSH15MIN,TSH30MIN,TSHBASELINE,TSHULTRASEN)@

@BRIEFLAB(CHOLESTEROL,CHOLESTEROLP,CHOLESTEPOCT,CHOLESTEROLC,TRIGLYCRIDE,TRIGLYCERIDES,TRIGLYCERIDT,HDL,HDLCHOLESTE,HDLPOINTOFCA,LDL,LDLCHOLCALC,DIRLDLCHOL,LDLDIRECTMEA,LDLPOINTOFCA,CHOLHDL,CHOLTOTALHDL)@

**Assessment/Plan**

Mr. @LNAME@ is a @AGE@ male with:

1. \*\*\*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

LJESTPE

**Physical Exam**

@VS@

@BMI@

General appearance: {General:10016600}

Head: {Exam; head:18723}

Eyes: negative

Abdomen: {Exam; abdomen:10016834::"normal findings: no masses palpable, no organomegaly, soft, non-tender"}

Male genitalia: {Exam; male genitalia:1005789}

Extremities: {Exam; extremity:1005109}

Skin: {Skin exam-one line:18725}

Neurologic: {Exam; neuro:10017854}

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

LJESTROS

**Review of Systems**

Constitutional: Negative for fever, chills, weight loss, weight gain.

Cardiovascular: Negative for chest pain.

Respiratory: Negative for shortness of breath.

Gastrointestinal: Negative for nausea, abdominal pain, diarrhea, constipation.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

LJRN1VISIT

Patient is here today for penile injection therapy training and education as well as to review his results.

Patient's familiarity with injection technique, risk, and complications is required for safe self administration of medication.

Under my direct supervision patient spend over 45 minutes face to face with a nurse in my office receiving injection instructions to start penile injection (ICI) program.

I have seen the patient, reviewed the chart to establish the appropriate dose, discussed the injection technique with patient and ordered vasoactive medication to be injected in the office today.

Patient was allowed to self stimulate.

Patient was seen by me after injection to assess his quality of erection and to answered any questions.

Please refer to nurse's note for details on patients education.

He will return for training session #2

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

LJRN3

Patient is here today for penile injection therapy training and education as well as to review his results.

Patient's familiarity with injection technique, risk, and complications is required for safe self administration of medication.

Under my direct supervision patient spend over 45 minutes face to face with a nurse in my office receiving injection instructions to start penile injection (ICI) program.

I have seen the patient, reviewed the chart to establish the appropriate dose, discussed the injection technique with patient and ordered vasoactive medication to be injected in the office today.

Patient was allowed to self stimulate.

Patient was seen by me after injection to assess his quality of erection and to answered any questions.

Please refer to nurse's note for details on patients education.

I have written the prescription for \*\*\*Trimix at \*\*\* units dose.

He will follow up in 3 months with the APP.

He will call my nurse to report on response.

He will use 2-3 injections a week.

GLSCROTAL PAIN

We discussed treatments to minimize testicular/scrotal discomfort today. These include daily sitz bath, NSAIDs, scrotal support with tighter underwear and pelvic floor relaxation. In addition, I recommended he use neurontin 100 mg TID for the next month to attempt to settle any nerve discomfort which may be present.

2. Follow up in 4 weeks for reevaluation. If not improved at that time, will consider spermatic cord block with marcaine to assess if the discomfort appears to originate in the testicle.

Litholink

**Litholink** \*\*\*/\*\*\*/\*\*\* (collected while on \*\*\*)

Volume (L/day) \*\*\*

SS CaOx \*\*\* (6-10)

Urine Calcium (mg/day) \*\*\* (male<250, female<200)

Urine Oxalate (mg/day) \*\*\* (20-40)

Urine Citrate (mg/day) \*\*\* (male>450, female>550)

SS CaP \*\*\* (0.5-2)

24 hr Urine pH \*\*\* (5.8-6.2)

SS Uric Acid \*\*\* (0-1)

Urine Uric Acid (g/day) \*\*\*

Anejaculation - Anejaculation refers to the failure to ejaculate, a situation in which the patient is usually capable of achieving an orgasm. The absence of orgasm is anorgasmia, and difficulty achieving orgasm is termed delayed orgasm. The lack of seminal fluid at the time of orgasm may be due to either retrograde ejaculation (RE) or failure of emission (FOE). RE in which seminal fluid travels into the urinary bladder is due to incompetence of the bladder neck. Thus, with orgasm, little or no seminal fluid is ejaculated. FOE, on the other hand, is the complete absence of seminal fluid deposition into the prostatic urethra. This results from greater impairment of the neural innervation of the seminal vesicles and the prostate. The causes can be subdivided into neurogenic (i.e., autonomic neuropathy or retroperitoneal surgery), medication (alpha-adrenergic blockers), and anatomic (bladder neck surgery or congenital) categories. The essential test is a post-orgasm urinalysis (also known as a retrograde semen analysis). The presence of semen and/or sperm in the first urine collection after orgasm defines retrograde ejaculation, whereas its absence defines FOE.

- Testosterone labs

- Post-orgasm Urinalysis (RDI)

Appattestation

I, Lawrence C Jenkins MD, have seen and examined the patient independently. I have personally reviewed all vitals, labs, and pertinent imaging. \*\*\*I have edited the APP's note to reflect my findings. Patient with \*\*\*. I otherwise agree with the history, physical exam findings, and medical decision making as stated by \*\*\*.

Risk Score Calculations:

10-y ASCVD Risk (40-75y) (ASCVD defined as nonfatal MI, CHD death, nonfatal and fatal stroke) = \*\*\*

Lifetime ASCVD Risk (20-59y) = \*\*\*

Ausconsult

Artificial urinary sphincter remains the gold standard for the treatment of male incontinence and will provide an initial success rate in the range of 90% of men having 0-1 pads per day, most using small pads for protection rather than heavy degrees of incontinence. The device has a mechanical reliability which is excellent, with few revisions (5%) required in the first 5 years. A 10-year continence rate will be in the range of 75%; although, revisions will be required in the majority of men by 10 years. The risk of bleeding and hematoma is low. Urinary retention may occur after artificial urinary sphincter, despite standardized deactivation of the device, and this may require suprapubic catheter drainage. Infection of the device occurs in 2-4% of patients, and is a serious complication which requires removal and replacement. This infection rate may be reduced by the now standard use of antibiotic coating. Erosion of the device usually relates to infection and has a 1-2% erosion rate. Recurrent incontinence may be as a result of urethral atrophy or device malfunction. These complications increase over time.

Ausopnote

**Date of Procedure**: \*\*\*

**PREOPERATIVE DIAGNOSIS:** Male stress urinary incontinence.

**POSTOPERATIVE DIAGNOSIS:** Male stress urinary incontinence.

**PROCEDURE PERFORMED:** Placement of artificial urinary sphincter.

**SURGEON: Lawrence Jenkins, MD**

**ASSISTANT: \*\*\***

**ANESTHESIA:** General.

**SPECIMENS:** None.

**COMPLICATIONS:** None.

**DRAINS:** A 12-French silicone Foley catheter.

**INDICATIONS:** The patient is a \*\*\* year-old gentleman with a history of radical prostatectomy. This has lead to male stress urinary incontinence. Workup in clinic has revealed he is a good candidate for artificial urinary sphincter. Informed consent was obtained for the procedure once the benefits, risks, and alternatives were discussed with the patient and his family and all of their questions were answered. The patient received antibiotic prophylaxis in a timely fashion preoperatively. SCD stockings were placed prior to induction of anesthesia.

**Description of the procedure:**

The patient was brought back to the operating room where he was given excellent general anesthesia and then was carefully placed into dorsal lithotomy position with appropriate padding and prepped and draped in the usual sterile fashion. The Foley catheter was placed. The meatus and exposed catheter were cleaned off using antibiotic solution once the balloon had been inflated to 10 mL and there was a return of clear urine. Ioban was then placed over the suprabubic skin. Incision was made along the perineal raphe. This was carried down sharply and with electrocautery until the bulbospongiosus muscle was identified. This was divided sharply in its midline and dissected free from the corpus spongiosum bilaterally. The Jordan retractor was placed. We began to dissect around the urethra. Care was taken to visualize the entirety of this so as not to make an injury to the urethra, particularly in the dorsal location. Once the urethra had been fully dissected free, an vessel loop was passed through this window. The urethra was dissected a little more to allow 2 cm window for the future cuff placement. A Toomey syringe was introduced into the meatus, and this was used to squirt in saline to look for evidence of urethra injury. No urethral injury was noted.

Attention was returned to the perineum. The measuring device was placed and an appropriate cuff size was chosen. Care was taken not to overtighten the measured cuff. A \*\*\* cm cuff was placed and the tab rotated to allow gentle curvature of the tubing toward the patient's \*\*\* side. An antibiotic-soaked gauze was placed into this location to pack the perineum and attention was turned to the right lower abdomen.

A small transverse incision was made over the belly of the right rectus approximately 3 finger-breadths above the pubic symphysis. The rectus fascia was identified, and a transverse fasciotomy was made sharply. Three separate 3-0 vicryl sutures were placed in the fascia. Using a non-muscle splitting technique, the fibers of the rectus were separated to expose the space of Retzius. The pressure-regulating balloon was placed in this location and was filled to 25 mL. The pre-placed fascial sutures were tied down with care not to injure the exiting tubing.

Attention was then turned to the scrotum. A ringed foreceps was obtained and a tunnel was created from the abdominal wound tracking down to the midline of the scrotum. The ringed foreceps were spread gently to create a subdartos pouch in this area. Once this was satisfactorily done, the pump was placed in this location, and then the tubing was grasped using a Babcock to keep it in location for the remainder of the case. The deactivation button was easy to palpate and device seemed to be in a nice superficial location.

Attention was returned to the perineum. The curved needle was used as a passer to pass the tubing into the abdominal incision. This was done while visualizing the cuff to make sure that this maneuver did not displace the cuff or rotate it in any way. Once this was accomplished, all of the tubings were flushed, and the connections were made in the usual fashion.

The device was deactivated. The abdominal wound was closed in multiple layers. Copious antibiotic solution was used to irrigate the wounds, just as they had been throughout the case. The perineum was closed in four layers including the bulbous spongiosum, one layer of fatty tissue, the Colles fascia, and then skin.

The wound was dressed. Dermabond was applied to the groin wound. The perineum had Telfa applied. The patient was then cleaned, awoken, and brought to the post anesthesia care unit in good condition. All of this was discussed with his family at termination of the procedure.

LJCA

@NAME@ returns today for ICI, and measurement of penile curvature. He has had no change in his medical history since his last visit. Consent obtained.

**Reason for Exam: Peyronie's Disease**

**ICI Injection for Tumescence**: Total injections: \*\*\* of \*\*\*

1. \*\*\* units

2. \*\*\* units

3. \*\*\* units

Stretched Flaccid Penile Length (Coronal sulcus to pubic bone) - \*\*\* cm

**Post-Injection Results**

**Rigidity -** \*\*\*/10. He states this is \*\*\* than at home

**Curvature -** \*\*\* degree \*\*\*.

**Other deformity -** \*\*\*

**Instability -** \*\*\*

Distance from coronal sulcus to the point of maximal curvature - \*\*\*cm

**ICI Injection for de-tumescence**: \*\*\* phenylephrine injected.

Patient was \*\*\*% rigid at discharge. He was advised to contact the office or go to an emergency room if his erection returned.

**Diagnosis:**

**1.** Peyronie's disease

Lawrence Jenkins, MD, performed the procedure.

**GRAPHIC PICTURES BELOW**

LJDADUS

***\*\*You are about to read part of the chart with sensitive personal information. This part of the chart should not be discussed without provider and patient approval.\*\****

**CC**

Penile deformity

**HPI**

Mr. @LNAME@ is a @AGE@ male who returns with \*\*\*.

Interval History:

@NAME@ returns today for ICI, penile doppler and measurement of penile curvature. He has had no change in his medical history since his last visit.

I have reviewed the patient's medical history in detail and updated the computerized patient record.

**Last visit \*\*\***

**Review of Systems**

Constitutional: Negative for fever, chills, weight loss, weight gain.

Cardiovascular: Negative for chest pain.

Respiratory: Negative for shortness of breath.

Gastrointestinal: Negative for nausea, abdominal pain, diarrhea, constipation.

**Past Medical History**

@CAPHE@ @PMHP@

**Past Surgical History**

@CAPHE@ @PSHP@

**Medications**

@CAPHE@ @CMEDP@

**Allergies**

@CAPHE@ @ALLERGYP@

**Social History**

@CAPHE@ @SOCHXP@

**Family History**

@CAPHE@ @FAMHXP@

**Physical Exam**

@VS@

@BMI@

General appearance: {General:10016600::"alert","cooperative","appears stated age"}

Head: {Exam; head:18723::"Normocephalic, without obvious abnormality","atraumatic"}

Eyes: negative

Abdomen: {Exam; abdomen:10016834::"normal findings: no masses palpable, no organomegaly, soft, non-tender"}

Male genitalia: {Exam; male genitalia:1005789}

Extremities: {Exam; extremity:1005109::"extremities normal, atraumatic, no cyanosis or edema"}

Skin: {Skin exam-one line:18725::"Skin color, texture, turgor normal. No rashes or lesions"}

Neurologic: {Exam; neuro:10017854::"Grossly normal"}

**Diagnostic Tests**

@LASTLABX(TESTOSTERONE:10,TESTOSTFR:10,SEXHORMBNDG:10,ESTRADIOLENH:10,PROLACTIN:10,FSH:10,LH:10,HCT:10,PSA:10,)@

**Radiographic Studies**

See report below

**Assessment/Plan**

Mr. @LNAME@ is a @AGE@ male with:

1. Peyronie's Disease - We discussed all the treatment options for Peyronie's Disease at length.

These include the following:

1. Observation. We discussed the likelihood of progression. Given that his curvature has stabilized, I would quote him a relatively low risk of progression. Overall, it is thought that a 10-12% of patients get better, a 60% stay the same and a 20-25% get worse. My experience is fewer get better and more get worse or stay the same.

We discussed that there are no oral therapies for Peyronie disease. The next option is a penile traction device. This is a mechanical traction device with limited data to support its use. However, the general concept of mechanical forces being able to help remodel structural abnormalities is not inconceivable. This would be considered off-label and without any strong evidence to support it.

2. The next option would be verapamil, delivered intralesionally. Intralesional verapamil has some moderate level of evidence is supported. A minimum of 6-injection treatments, separated by 2 weeks each, over a 3-month period is associated with a reduction in curvature and pain. In our experience, we have seen more stabilization, pain reduction and fewer improvements. Intralesional verapamil hasa very limited side effect profile with the possibility of bruising the therapy.

3. The next option would be Xiaflex (collagenase), delivered intralesionally. Intralesional collagenase has recently been FDA approved for the treatment of stable, dorsal and/or lateral curvatures. The average improvement was 17 degrees (34%). The treatments include 4 cycles of 2 injections separated by approx 1 week followed by a six week break. This is combined with penile traction therapy which is begun 1 week after the second treatment. Total therapy takes about 24 weeks.

4. Final option would be surgical interventions.

-For moderate curvature, without significant hourglass narrowing, and good erectile function, penile plication offers a simple, safe approach. The principle involves placing sutures in the side opposite the curvature. These plication sutures in the tunica albuginea slightly shorten the tunica albuginea to normal or long side of the penis. The chance of correcting the curvature to within 5 degrees of normal is over 95%. The risks are relatively limited including a small risk of infection, bruising and numbness. The risk of erectile dysfunction is limited. It is an outpatient procedure, it takes 1 hour to perform, and has a limited pain and time away from work.

-The alternative approach is incision of the plaque and grafting. This is a more extensive procedure which involves mobilization of the neurovascular bundle dorsally, or corpus spongiosum ventrally, an incision through the tunica albuginea at the point of scarring, and placement of a graft in to substitute for the tunica albuginea. This operation takes approximately 2-3 hours to complete and has a considerably longer penile rehabilitation period. It may take up to 8-9 months to fully regain sexual function. There are also significant risks of erectile dysfunction with this approach. There is also risk of numbness when we are mobilizing the dorsal neurovascular bundle. In my experience, these have all resolved, but it takes 3 to 6 months for resolution to occur. Ninety-five percent of patients have a straight penis, but in the few residual patients with persistent curvature, plications may be effective.

When the condition is stabilized and there is no new curvature for 3-6 months, then xiaflex or surgery is appropriate. Patients with severe curvature, very significant shortening, or profound hourglass narrowing need grafting procedures. All other patients are potentially candidates for penile plication with its lower risk profile.

A penile implant may be an option for those patients with bad erectile dysfunction and penile deformity. Often times the rigidity of the implant resolves most of the curvature.

**Plan:** \*\*\*

Today's visit occupied approximately 20\*\*\* min of my time with greater than 50% in direct face-to-face consultation spent counseling and coordinating care including discussing my findings with the patient, explaining the rationale for my recommendations and answering questions.

**CAVERNOSAL DUPLEX SCAN**

@NAME@ returns today for ICI, penile doppler and measurement of penile curvature. He has had no change in his medical history since his last visit. Consent obtained.

The penile color duplex exam is used to assess the integrity of the penile vasculature in the diagnosis of erectile dysfunction. This is done by measuring the flow velocity after an intracorporeal injection of medication. In patients with normal arterial inflow, peak systolic velocity (PSV) after injection should exceed 30 cm/sec. End diastolic velocity/flow (EDV) should be less than 5 cm/sec. The clinical response (erections) should estimate the intactness (+/-) of the venous occlusion mechanism, but cannot exclude subtle forms of venous insufficiency, inhibited autonomic outflow or totally psychogenic factors.

**Reason for Exam: Penile Deformity\*\*\***

**\*\*\***

**Diagnosis:**

**1.** \*\*\*Normal hemodynamics

**2.** \*\*\*Peyronie's disease

Lawrence Jenkins, MD, performed the procedure, reviewed the obtained and saved images.

**GRAPHIC PICTURES BELOW**

Ljclom

**Clomiphene 50 mg off-label PO every Mon, Wed, Fri**

**Labs in 3-4 wks (Total and Free Testosterone, Estradiol, LH, H/H)**

Cordblock

**Complications:** None

**Indication:** Persistent bilateral testicular pain that failed conservative management

**PROCEDURE** - Patient agreed to bilateral spermatic cord block after we discussed the risks and benefits. Groin and upper scrotum was cleaned with alcohol bilaterally. 5 cc 0.5% marcaine mix was injected into the right spermatic cord. 5 cc 0.5% marcaine mix was injected into the left spermatic cord. Patient tolerated procedure well without complications.

I, Lawrence Jenkins, MD, performed the procedure myself.

Cancersurghx

Type of Surgery: \*\*\*

Surgeon/location: \*\*\*

Nerve sparing status: \*\*

Radiation: \*\*\*

Radiation Oncologist: \*\*\*

ADT (including duration): \*\*\*

Chemo: \*\*\*

Congenital Penile Curvature - We discussed all the treatment options for CPC at length.

These include the following:

1. Observation. I would quote him a relatively low risk of progression. The next option is a penile traction device. This is a mechanical traction device with limited data to support its use. However, the general concept of mechanical forces being able to help remodel structural abnormalities is not inconceivable. This would be considered off-label and without any strong evidence to support it.

2. Final option would be surgical interventions.

-For moderate curvature, without significant hourglass narrowing, and good erectile function, penile plication offers a simple, safe approach. The principle involves placing sutures in the side opposite the curvature. These plication sutures in the tunica albuginea slightly shorten the tunica albuginea to normal or long side of the penis. The chance of correcting the curvature to within 5 degrees of normal is over 95%. The risks are relatively limited including a small risk of infection, bruising and numbness. The risk of erectile dysfunction is limited. It is an outpatient procedure, it takes 1 hour to perform, and has a limited pain and time away from work.

-The alternative approach is incision of the plaque and grafting. This is a more extensive procedure which involves mobilization of the neurovascular bundle dorsally, or corpus spongiosum ventrally, an incision through the tunica albuginea at the point of scarring, and placement of a graft in to substitute for the tunica albuginea. This operation takes approximately 2-3 hours to complete and has a considerably longer penile rehabilitation period. It may take up to 8-9 months to fully regain sexual function. There are also significant risks of erectile dysfunction with this approach. There is also risk of numbness when we are mobilizing the dorsal neurovascular bundle. In my experience, these have all resolved, but it takes 3 to 6 months for resolution to occur. Ninety-five percent of patients have a straight penis, but in the few residual patients with persistent curvature, plications may be effective.

CPCdiscussion

We discussed all the treatment options for Congenital penile curvature at length.

These include the following:

1. Observation. We discussed the likelihood of progression. Given that his curvature has stabilized, I would quote him a relatively low risk of progression.

2. For moderate curvature, and good erectile function, penile plication offers a simple, safe approach. The principle involves placing sutures in the side opposite the curvature. These plication sutures in the tunica albuginea slightly shorten the tunica albuginea to normal or long side of the penis. The chance of correcting the curvature to within 5 degrees of normal is over 95%. The risks are relatively limited including a small risk of infection, bruising and numbness. The risk of erectile dysfunction is limited. It is an outpatient procedure, it takes 1 hour to perform, and has a limited pain and time away from work.

**Cystourethroscopy**

ATTENDING: Lawrence Jenkins, MD

RESIDENT: \*\*\*

PREOPERATIVE DIAGNOSIS(ES):{History; gu diagnosis:62019697}

POSTOPERATIVE DIAGNOSIS(ES): Same

PROCEDURE PERFORMED: Flexible Cystourethroscopy

ANESTHESIA: 2% plain lidocaine jelly

INDICATIONS: \*\*\*

PROCEDURE DETAILS:

The patient was properly identified. Consent was obtained. The patient was placed in supine position and prepped and draped in standard fashion with lidocaine jelly per urethra for anesthesia. The flexible cystoscope was lubricated and placed through the urethra and into the bladder. The bladder was completely visualized. The scope was then retracted and the procedure terminated. The patient was discharged in good condition. The findings revealed \*\*\* normally positioned and appearing ureteral orifices. The bladder neck was \*\*\*. There were no tumors, stones or patches of erythema. There was \*\*\* trabeculation. The prostatic urethra was \*\*\*. There were \*\*\* urethral strictures noted.

COMPLICATIONS: None

PLAN: \*\*\*

\*\*\* was present in the procedure room for the entire procedure.

IPP Dischargeinstructions

**DR. JENKINS’ POSTOPERATIVE INSTRUCTIONS FOR**

**PENILE IMPLANT SURGERY**

**YOU ARE TO EXPECT**

1. Small amounts of drainage on your dressings
2. Pain, tenderness, swelling and bruising for several days after your surgery.
3. Nausea may be experienced the day of your operation after you return home.
4. You should already have prescriptions for pain medicine and antibiotics.
5. You should already have an appointment for a post-operative visit with Dr. Jenkins within the first 2 weeks after your surgery.

**INSTRUCTIONS**

1. Keep the mummy wrap dressing on until Friday\*\*\* evening.
2. Keep the extra gauze dressing used for compression in place until Sunday\*\*\*.
3. If the scrotal dressing becomes soiled replace it with a similarly sized clean gauze dressing.
4. Keep the scrotal support on for at least one week.
5. Position your penis upwards on your abdomen as much as possible.
6. For 2-3 days, place an ice pack inside the scrotal support (not directly in contact with skin).
7. Drink plenty of fluids.
8. Eat lightly the remainder of the day of surgery, then return to normal diet as tolerated.
9. Make sure your bowels function normally since pain medications can cause constipation. You may need to use stool softeners such as MiraLax to help your bowels function normally.
10. Finish your antibiotics completely.
11. You may shower on Friday\*\*\*, but avoid tub baths for 2 full weeks.
12. You may walk around the home and upstairs immediately, but carefully.
13. When sitting raise your legs.
14. Do not drive until at least one week after surgery.
15. Do not lift any heavy objects (greater than 10 lbs) for at least 2 weeks after surgery.

**CALL FOR THE FOLLOWING REASONS**

1. Fevers over 101 degrees.
2. Excessive drainage from your wound, especially blood or pus
3. Pain or scrotal swelling that is not improving after the first week following surgery
4. Redness around the wound.

**CONTACT NUMBERS**

1. For questions during office hours (Mon-Fri 9am-5pm) call 614-293-8155.
2. For any emergency questions on weekends/outside of office hours, call **614-293-8000** and ask to speak to the physician on-call**.**

LJDIPEYRONIES

**THE SEXUAL & REPRODUCTIVE MEDICINE PROGRAM**

**The Ohio State University Department of Urology**

*Committed To Treatment, Education and Research In Disorders Of Sexual & Reproductive Function*

# **DR. JENKINS’ POSTOPERATIVE INSTRUCTIONS FOR**

# **PEYRONIE’S DISEASE SURGERY**

# **YOU ARE TO EXPECT**

1. Small amounts of drainage on your dressings
2. Pain, tenderness, swelling and bruising for several days after your surgery.
3. Nausea may be experienced the day of your operation after you return home.
4. You should leave with prescriptions for pain medicine.
5. You should also leave the hospital with an appointment for a post-operative visit with Dr. Jenkins within the first 2 weeks after your surgery.

# **INSTRUCTIONS**

1. If you have a dressing around your penis, remove it 2 days after surgery.
2. Keep any scrotal compression dressing on until 2 days after surgery.
3. If the scrotal dressing becomes soiled replace it with a similarly sized clean gauze dressing.
4. Keep the scrotal support (if there is one) on for at least one week.
5. Position your penis upwards on your abdomen as much as possible.
6. For 2 days, place an ice pack over the penis (not directly in contact with skin).
7. Drink plenty of fluids.
8. Eat lightly the day of surgery, then return to normal diet as tolerated.
9. Make sure your bowels function normally, as pain medications are constipating.
10. You may need to use stool softeners, MiraLax, to help your bowels function normally.
11. You may shower 2 days after surgery, after the penis dressing is removed.
12. Avoid tub baths for 2 full weeks.
13. You may walk around your home and up stairs immediately, but carefully.
14. When sitting raise your legs.
15. Do not drive until at least 2 days after surgery.
16. Do not lift any heavy objects (greater than 10 lbs) for at least 2 weeks after surgery.

# **CALL FOR THE FOLLOWING REASONS**

1. Fevers over 101 degrees.
2. Excessive drainage from your wound, especially blood or pus
3. Pain or scrotal swelling that is not improving after the first week following surgery
4. Redness around the wound.

## **CONTACT NUMBERS**

1. For questions during office hours (Mon-Fri 8am-4:30pm) call 614-293-8155.
2. For any emergency questions on weekends/outside of office hours, call **614-293-8000** and ask to speak to the physician on-call**.**

LJDDIScrotal

**THE SEXUAL & REPRODUCTIVE MEDICINE PROGRAM**

**The Ohio State University Department of Urology**

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# **DR. JENKINS’ POSTOPERATIVE INSTRUCTIONS FOR**

# **SCROTAL SURGERY**

# **YOU ARE TO EXPECT**

1. Pain and tenderness in your scrotum for a few days after surgery.
2. Bruising on your scrotum and penis.
3. You should leave with prescriptions for pain medicine.
4. You should also leave with an appointment for a post-operative visit with Dr. Jenkins in approximately 10 days.

# **INSTRUCTIONS**

1. Keep the “mummy wrap” compression dressings on until Friday evening.
2. Keep the extra gauze in place until Sunday.
3. Keep the scrotal support on for at least one week post-operatively.
4. For the first 2 days use an ice pack inside the scrotal support.
5. Make sure your bowels continue to function normally.
6. You may shower on the Saturday.
7. You may walk around the home and up stairs immediately, but carefully.
8. When sitting elevate your legs.
9. Do not drive until at least 4 days post-op.
10. Do not lift any heavy objects (10 lbs or greater) for at least 2 weeks after surgery.

# **CALL FOR THE FOLLOWING REASONS**

1. Fevers over 101 degrees.
2. Excessive pain.
3. Excessive drainage from your wound, especially blood or pus.

## **CONTACT NUMBERS**

1. For questions during office hours (Mon-Fri 9am-5pm) call 614-293-8155.
2. For any emergency questions on weekends/outside of office hours, call **614-293-8000** and ask to speak to the physician on-call**.**

LJDIVV

Vasovasostomy or Vaso-epididymostomy: Post-Operative Care

1. **It is likely that you will have some discomfort for the first 2 – 3 weeks after surgery.** At the time of discharge from the hospital, you will have been given a prescription for pain medication. When taking pain medication, be careful as you walk or climb stairs. Dizziness is not unusual.
2. **Swelling and bruising of the penis and scrotum are normal.** This takes about 3 weeks to completely resolve.
3. **Applying ice to the incision for 48 hours post-operatively will help decrease pain and swelling.**
4. **In some patients, rubber drains are left in the scrotum and will be removed the morning after the operation.** An instruction sheet for removal will be given to you at the time of discharge. If you or your spouse are uncomfortable removing the drains, you may return to Dr. Jenkins’ office the next day and the nurse will remove them. Please contact the nurse at 614-293-8155 if you would like an appointment to have the drains removed.
5. A small amount of bright red blood showing through the gauze dressing is to be expected. **Do not be alarmed.** If you feel the amount is excessive, call my office. You may replace bloody bandages with clean ones. If there isn’t any bleeding the wound need not be covered with gauze.
6. Do not make any important judgment decisions or sign any legal documents for 24 hours after anesthesia.
7. A low-grade fever [to 101oF] is common 2 – 3 days post-operatively. This fever can be lessened by coughing, deep breathing and walking. There is no danger that these activities will disrupt your incisions. Taking pain medication one hour before activities and placing a pillow over your lower abdomen when coughing will help decrease discomfort.
8. There are no stitches that need to be removed. The stitching is beneath the skin and dissolves.
9. **You should shower 48 hours after the surgery.** Before showering, remove the scrotal supporter and gauze dressings. Dry yourself well after showering and wear a clear scrotal supporter daily. **DO NOT** remove the steri-strips until 10 days after surgery; you may shower with the steri-strips in place. It is important to keep the surgical area clean. Allow the warm water to run over the incisions in the shower and wash gently with soap. (Do not rub hard or scrub the incision or steri-strips).
10. **You will need to wear the scrotal supporter (jock strap) or compression shorts** **at all times, even while sleeping, for 6 weeks post-operatively.** It may only be removed while showering. After 6 weeks, wear the scrotal supporter / compression shorts when walking, running, engaging in sports or strenuous activity. The purpose of the scrotal support is to prevent your testicles from pulling down on the reconnected ducts.
11. To prevent fungus infection (jock itch), dry yourself well after showering and wear a clean scrotal supporter daily. If jock itch should occur, use a combination of Lamisil 1% Cream and Hydrocortisone 1% Cream, which can be purchased over the counter. Mix equal parts of each and apply to the area 3 times daily.
12. Do not take tub baths for at least one week after surgery.
13. **Do not drive for 3 days after surgery**, but you can ride in a car if someone else is driving.
14. **No heavy work, strenuous exercise or sports are allowed for 3 weeks post-operatively.**
15. If your job involves only desk work and light activity, you may return to work 2 to 3 days after surgery.
16. **No sexual intercourse is allowed for four weeks post-operatively** in order to avoid disturbance of the delicate connections and prevent contractions of the vas deferens (which occur during orgasm) until healing is complete.
17. Thereafter, you may resume normal activities as you feel up to it.
18. Remember that the Codeine/Hydrocodone/Oxycodone in your pain medication can cause constipation. To avoid straining, increase your fiber intake [fruits, vegetables, whole-grains, etc.]. Drinking lots of water can also help. If necessary, you can take two tablespoons of Milk of Magnesia at bedtime. You may also take Colace (stool softener) while you are taking pain medication.
19. **Follow up visit:** If you live in the Columbus area, we ask that you **call the office/lab ASAP** after surgery to make an appointment for a post-operative semen analysis/cryopreservation in one month at Reproductive Diagnostics and examination by Dr. Jenkins in 5-6 weeks.

You should have a semen analysis after the surgery at **1 month, 3 months, 6 months and every 6 months thereafter until your partner becomes pregnant.**

At the time of your 3-month semen analysis, a **blood specimen** will also be obtained for determination of anti-sperm antibody levels.

In general, it will take between 3 and 12 months for sperm counts to return to normal, although on some occasions it make take up to 2 years.

**If you have any questions, please feel free to call the office.**

**PLEASE INFORM THE OFFICE IMMEDIATELY OF ANY PREGNANCY!**

LJDUS

@NAME@ returns today for ICI, and penile doppler. He has had no change in his medical history since his last visit.

**CAVERNOSAL DUPLEX SCAN**

The penile color duplex exam is used to assess the integrity of the penile vasculature in the diagnosis of erectile dysfunction. This is done by measuring the flow velocity after an intracorporeal injection of medication. In patients with normal arterial inflow, peak systolic velocity (PSV) after injection should exceed 30 cm/sec. End diastolic velocity/flow (EDV) should be less than 5 cm/sec. The clinical response (erections) should estimate the intactness (+/-) of the venous occlusion mechanism, but cannot exclude subtle forms of venous insufficiency, inhibited autonomic outflow or totally psychogenic factors.

**Reason for Exam: \*\*\***

**ICI Injection for Tumescence**: Total injections: \*\*\* of \*\*\*

1. \*\*\* units

2. \*\*\* units

3. \*\*\* units

Stretched Flaccid Penile Length (Coronal sulcus to pubic bone) - \*\*\* cm

**Post-Injection Results**

**Rigidity -** \*\*\*/10. He states this is \*\*\* than at home

**Left Cavernosal Artery:**

PSV: \*\*\* cm/sec

EDV: \*\*\* cm/sec

RI: \*\*\*

**Right Cavernosal Artery:**

PSV: \*\*\* cm/sec

EDV: \*\*\* cm/sec

RI: \*\*\*

**ICI Injection for de-tumescence**: \*\*\* phenylephrine injected.

Patient was \*\*\*% rigid at discharge. He was advised to contact the office or go to an emergency room if his erection returned.

**Diagnosis:**

**1.** \*\*\*Normal hemodynamics

**2.** \*\*\*

Lawrence Jenkins, MD, performed the procedure, reviewed the obtained and saved images.

Ljdusdescription

**Penile Duplex Doppler Ultrasonography Study**

Procedure Description:

This procedure involves the injection of a drug combination of Papaverine, Phentolamine and Prostaglandin E-1 into the penis. The drugs cause a dilation of the blood vessels supplying the penis, thus causing an erection. Men with diseased blood vessels which may be caused by high blood pressure, arteriosclerosis, diabetes, etc., will not develop a full erection. Men with abnormal veins will also not develop a full erection. The purpose of this examination is to take a close look at the arteries of the penis. Therefore, the test will tell us whether the erectile dysfunction is due to arterial vascular disease.

The ultrasonography part of the procedure involves measuring the penile arteries before and after the injection of the medication: If the arteries were normal, we expect them to dilate. The Pulsed Doppler is utilized to look at the increase in blood flow. An increase in blood flow will occur if narrowing of the larger arteries supplying blood to the penile arteries is present. A venous leak is considered when no erection is noted despite normal arterial dilation and normal blood flow.

As with medical tests there are possible complications. Approximately 5% of men will develop a small bruise at the injection site which will resolve within 7 to 10 days and cause no further problems. Dizziness has been reported, though it is rare, but this is resolved by lying down for a short period. Some might develop a full erection which can last for many hours. If this occurs, we will have to inject an additional medication to bring the erection down.

No special preparation is required and we will gladly answer ·any questions you have regarding this test when you report for the procedure.

Thank you.

Ljdviu

**Preoperative diagnosis**

Urethral stricture

**Postoperative diagnosis**

Urethral stricture

**Procedure performed**

1. Rigid cystoscopy

2. Urethral dilation over a guide wire up to \*\*\* Fr

3. Direct vision internal urethrotomy (DVIU)

**Attending surgeon**

Lawrence Jenkins, MD, MBA

**Resident**

\*\*\*

**Anesthesia**

General

**EBL**

50 mL

**Complications**

None

**Specimen**

Tissue from bladder neck for permanent pathology

**Findings**

Cystourethroscopy revealed \*\*\* Fr tight urethral stricture at the \*\*\* urethra with dystrophic tissue from prior radiation was present. There was at least \*\*\* length bladder neck contracture extending down to \*\*\* urethra.

There were no abnormalities within the bladder with no bladder tumors or stones. Ureteral orifices were in the normal anatomic position.

Post-procedure cystoscopy revealed bilateral ureteral orifices that were uninvolved.

**Indications**

@AGE@ y.o. male with history of \*\*\* s/p \*\*\* with adjuvant radiation who presented to our clinic for evaluation of urethral stricture. He has had \*\*\* incontinence since his radiation as well as \*\*\* urinary retention. He has been managed with \*\*\* indwelling catheter, urethral dilation and CIC. He is interested in artificial urinary sphincter (AUS). Work up in our clinic with retrograde urethrogram and office cystoscopy showed \*\*\* stricture. He was informed that aggressive DVIU is a reasonable place to start. The patient was also informed to have worsening incontinence. Should he demonstrate patency for a period of 3 months he will be candidate \*\*\* for AUS insertion. After counseling, he agreed to undergo the above named procedure after discussion of the alternatives, risks and benefits. Informed consent was obtained.

**Procedure**

The patient was taken to the operating room and placed supine on the operating table. Pre-operative antibiotics were administered. Bilateral lower extremity SCDs were placed. After induction of general anesthesia the patient was positioned in dorsal lithotomy. A time-out was performed. The patient was prepped and draped in a sterile fashion.

A 21-French rigid cystoscope was passed carefully via urethra into the urethra with findings noted above. A sensor wire was passed retrograde through the urethral stricture lumen into the bladder. The rigid scope was off-loaded. Sequential urethral dilation performed using S-sharp curved urethral dilators starting from \*\*\* Fr over the sensor wire that was switched to a super-stiff wire until \*\*\* Fr dilation reached.

A 21 French continuous flow rigid cystoscopy was introduced into the urethra and and was able to pass carefully into bladder after removing the super stiff wire. Maneuverability of the scope was limited given the tightness of the bladder neck.

Using the Collins knife of the working element for the cystoscopy, initial incisions were made at 3 & 9 o'clock at the bladder neck at setting of \*\*\* 120/60 for cut and coags respectively. This allowed to open up the bladder neck and free maneuverability of the scope. Formal cystoscopy performed with findings noted above.

At this point, we reassessed the area at the bladder neck and found to have at least ~ \*\*\* cm bladder neck contracture extending down to \*\*\* urethra. This contracture was incised by making 2 incisions starting at 5 & 7 o'clock positions bilaterally down to the distal stricture at membranous urethra. Hemostasis was obtained with Bugbee electrode. Resection pieces were flushed out of the bladder and sent for pathology. The bilateral ureteral orifices were used as landmarks and repeatedly visualized throughout the procedure. At the end of the procedure, a nice opened bladder neck achieved. A \*\*\* 20 French coude catheter was placed without difficulty with \*\*\* 20mL saline in balloon. Clear urine drained immediately. The patient tolerated the procedure well, was awakened, extubated and transferred to the recovery room in stable condition.

I, Lawrence Jenkins, MD, MBA, was present in the procedure room the entire duration of the case

Edmedresult

**With \*\*\***, he rates his erectile rigidity as a **\*\*\*** on a scale of 0-10 (with 6 being just firm enough for penetration).

Edplan

-We discussed ED etiology, causes, and treatment options. \*\*\*Being that ED can be a warning sign for CV disease I have recommended a referral to a medical physician for evaluation and consideration of non-invasive CV testing.

-Counseled extensively on **diet, exercise, improving sleep, and stress reduction**. We discussed that early weight loss can stop progression of ED and in some cases reverse ED severity.

-We discussed ED treatment including PDE-5 inhibitors, Vacuum erection device, MUSE, injection therapy, and Penile prosthesis placement.

-start with trial of \*\*\* mg prn. Discussed dosing, risk, benefits, and alternatives. Rx sent to pharmacy.

-sex therapy\*\*\*

Edriskfactors

Additional Significant Risk Factors:

Smoking?: {Desc; yes/no/not asked:20018710::"no"}

Hypertension:? (BP≥140/90 or taking meds)? {Desc; yes/no/not asked:20018710::"no"}

Low HDL (<40 mg/dL)?: {Desc; yes/no/not asked:20018710::"no"}

CKD (with eGFR <60 ml/min) (risk of coronary death or nonfatal MI among CKD pts >50 is >10% and LDL-C is not suitable for assessing risk)?: {Desc; yes/no/not asked:20018710::"no"}

CKD (with eGFR ≥60ml/min)?: {Desc; yes/no/not asked:20018710::"no"}

Other (i.e. HIV, transplant)?: {Desc; yes/no/not asked:20018710::"no"}

Baseline Metabolic Syndrome Criteria:

Abdominal obesity (men waist >40, women >35)?: {Desc; yes/no/not asked:20018710::"no"}

Triglycerides ≥ 150 mg/dL?: {Desc; yes/no/not asked:20018710::"no"}

Low HDL (male <40 mg/dL, female <50 mg/dL)?: {Desc; yes/no/not asked:20018710::"no"}

Hypertension ≥135/85?: {Desc; yes/no/not asked:20018710::"no"}

Fasting glucose ≥100 mg/dL?: {Desc; yes/no/not asked:20018710::"no"}

Total = \*\*\* (≥3 meets criteria for Metabolic Syndrome)

NLA Major Risk Factors for ASCVD

{Risk Factors; ATP (Adult Treatment Panel) 3 Major Risk Factors:21636}

Total:

Erectionscale

Please rate your level the hardness of your erections on a scale from 0 – 10, \*\*\***with your partner**.

0 - Penis does not enlarge.

1 -

2 -

3 - Penis is larger, but not hard.

4 -

5 - Penis is full, but not hard enough for vaginal penetration.

6 - Penis is just hard enough for vaginal penetration, but not completely hard.

7 - Penis is just hard enough for anal penetration, but not completely hard.

8 -

9 -

10 - Penis is completely hard and fully rigid.

        \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/10

Benignexcision

**OPERATIVE REPORT: BENIGN EXCISION of scrotal lesion(s)**

Surgeon: @ME@

Resident: \*\*\*

Site: \*\*\*

Post-procedure Diagnosis: \*\*\*

Post-op size: \*\*\*

Indication: \*\*\*

Depth extended to: SubQ

Estimated Blood Loss: <5mL

Prophylaxis antibiotic: Not indicated

Pacemaker: No

The risks, complications, and alternatives to the procedure were explained in detail and informed consent was obtained. The described risks include but are not limited to scarring, bleeding, infection, pain, discoloration, numbness, nerve damage leading to loss of muscle movement, recurrence, and spread of the lesion.

PROCEDURE: Prior to beginning, permission for the procedure was signed and on the chart. With the patient in the supine position and under adequate local anesthesia with 0.25% bupivicaine, the defect was scrubbed with Hibiclens. Sterile drapes were placed from the sterile tray. The lesion was excised down to the subcutaneous tissue. Careful planning of removal of redundant tissue at either end of the defect was drawn out so that the suture lines would fall in the optimal orientation with regard to the relaxed skin tension lines. These were then removed with a #15 blade scalpel. Hemostasis was obtained by electrocoagulation. The wound was then approximated with simple interrupted sutures of 4-0 Biosyn suture. Estimated blood loss was less than 5 mL.

The patient tolerated the procedure well. The wound was dressed with antibiotic petrolatum, a non-stick pad. The final incision was \*\*\* cm in length. Wound care was discussed with the patient, and a wound care instruction sheet was given.

Complications: none

Post-op medications: none

Patient condition after procedure: stable

Operative time: 45 minutes

Discharge plans: return for as needed

Female over 50

**Sex Health Blog – SexHealthMatters.org**

Oct 29, 2014

**Sex for Women After 50**

What is sex like for women over 50?

It’s a question many women have, especially as they approach menopause. This “change of life” is driven by declines in the hormone estrogen. The ovaries stop releasing eggs and menstruation ceases.

In North America, the average age for menopause is 51, so it’s fitting that we start our discussion here. But this is just an average. Some women go through menopause later. Some experience it in their thirties or forties. And some may go through surgical menopause if they have had their ovaries removed.

Generally speaking, a woman is considered to be finished with menopause when she has not had a menstrual period for twelve months. Before that, she is said to be in perimenopause, when estrogen levels tend to fluctuate. Her periods may become erratic. They might be heavy one month and light the next. She might feel fatigued, get headaches, have hot flashes, and become moody. And during this time, she can still become pregnant.

Her sex life can change, too. Estrogen is important for sexual health. It keeps vaginal tissues healthy and plays a role in sex drive.

But drops in estrogen levels don’t signal the end of a woman’s sex life. Not at all. In fact, some women say sex is better after menopause, especially when pregnancy is no longer a concern. (However, postmenopausal women can still acquire sexually-transmitted infections – and many do. Safe sex practices are just as important after menopause as before.)

Let’s take a quick look at some of the sexual issues often faced by women after 50:

Painful intercourse. When you were younger, you probably had few problems with vaginal lubrication when you became sexually excited. Unfortunately, this changes for many women as they get older. Declines in estrogen mean the vagina is less moist. It’s also less flexible. As a result, sex can become painful. Friction from penetration can irritate the dry vaginal tissue.

Many women find that a personal lubricant is helpful. Lubricants can be purchased over the counter at the drugstore and come in many varieties. (Be sure to choose a water-based lubricant if you are using condoms.) Moisturizers are also available. You might also consider hormone replacement therapy, if your doctor thinks it is safe for you.

A medication called Osphena is another possibility. This drug acts like estrogen and helps keep the vagina moist and flexible.

Low sex drive. When estrogen levels fall, so can a woman’s sex drive. However, menopause is not the only culprit. Many women over 50 have a lot on their plates. They may be working full time, raising children, preparing adolescents for adulthood, and caring for aging parents. Sometimes, the stress and anxiety of daily life makes a woman so exhausted that she’s not interested in sex.

If you lose some sexual spark, talk to your doctor. He or she can help pinpoint the problem. Hormone replacement therapy might be appropriate.

If you’re feeling stressed, see what you can do to relax. Talk to a friend, ask for help from family, or talk to a counselor. Have a night out with the girls or try a new exercise class at the gym.

Be sure to keep your partner in the loop, too. Chances are, he or she has noticed the changes in your relationship. Talk over your difficulties and try to make time for just the two of you. Keeping lines of communication open may make you stronger as a couple. A counselor or sex therapist may help, too.

Needing more time. You might notice that takes you longer to become fully aroused or to reach orgasm. This is quite common. Try not to worry too much about it. If you need more foreplay, explain that to your partner. Then relax and enjoy the experience.

Sometimes, changing the routine is all that’s needed. You might consider other sexual positions, have sex in other locations, share fantasies, or try out some sex toys. (Remember, too, that your partner might need more time as well. For example, men might need more stimulation to get a firm erection. You can find more information about sexual changes for men over 50 here.)

It’s important to note that while menopause is often a big contributing factor to sexual issues at this age, it is not the only factor. Health conditions like diabetes, heart disease, arthritis, and depression can also cause sexual difficulties. If you are having a sexual problem, be sure to discuss it with your gynecologist. The solution may be something simple, like a lubricant or experimenting with a new sexual position. Or, it may be more complicated and require medication or lifestyle changes.

**The following links can help you learn more about sex and aging for women:**

Back Pain Isn’t the End of Sexual Satisfaction

Dealing with Arthritis

Osphena Approved to Treat Painful Sex

Sex Health and Aging for Women

Sexual Satisfaction and Aging

STD Tests for the Elderly

STDs and Safe Sex

Vulvar and Vaginal Atrophy

Print this article or view it as a PDF file here: Sex for Women After 50

**Resources**

The North American Menopause Society

“Sexual Health & Menopause Online”

(Complete series. 2014)

http://www.menopause.org/for-women/sexual-health-menopause-online

The Menopause Book

Wingert, Pat and Barbara Kantrowitz

“Chapter 5 – Sex”

(Workman Publishing. 2009. Pages 97 – 137)

http://www.workman.com/products/9780761155980/

WomensHealth.gov (U.S. Department of Health and Human Services)

“Menopause and sexuality”

(Last updated: September 22, 2010)

http://www.womenshealth.gov/menopause/menopause-sexuality/index.html#pubs

fertilitylifestyleinfo

**Men's Health and Fertility Lifestyle Information**

**Patients with infertility can have some control of their reproductive function by living healthy lifestyles. "Negative" lifestyles can contribute to infertility. There is medical evidence supporting these lifestyle recommendations.**

**Tips**

1. Males should avoid excessive heat (jacuzzi, saunas, hot tubs, etc.)
2. Avoid placing laptop computers on lap or placing cellphones in front pants pockets.
3. Limit coffee to 20 ounces per day.
4. Do not smoke.
5. Do not use marijuana, cocaine, or other recreational drugs. Marijuana stays in the testes for two weeks, so even using it once every two weeks will have a negative effect.
6. Exercise regularly and moderately.
7. Drink no more than a total of 6 alcoholic beverages per week (glasses of wine, cans of beer, shots of liquor). Females should abstain from alcohol if pregnant.
8. Have good nutritional habits, especially a diet rich in fresh fruits and leafy vegetables (oranges, tomatoes, peppers, leafy greens – any bright-colored fruit or vegetable), as well as fish (SMASH: salmon, mackerel, anchovies, sardines and herring). Avoid excess of animal fat (red meat, fried food, cheese and whole milk). Diets high in animal fat are associated with a high risk of prostate cancer and heart disease. Meats lower in animal fat include venison, buffalo and grass-fed beef.
9. Be aware of sexual problems and do not hesitate to ask for medical help.
10. Seek emotional and/or psychological support; consider meditation to reduce stress.
11. Do not use finasteride (Propecia, Proscar) for hair loss. There is accumulating evidence that it negatively impacts male fertility. You may instead use topical minoxidil (Rogaine), which has no known negative effects on male fertility.

**Vitamins**

There is evidence that antioxidant vitamins and supplements may improve male fertility. Infertile men have a higher concentration of free radicals in their semen compared to fertile men. Free radicals attack the membrane that surrounds sperm.

**Dr. Jenkins recommends:**

1. Vitamin C: 500 mg/day
2. Selenium: 100 mcgs/day
3. CoQ10: 200 mg/day
4. Vitamin E: 200 IUs/day
5. Folic Acid: 400 mcg/day
6. Multivitamin that contains no more than 20 mg of zinc and no more than 200 IUs of Vitamin E.

There is a product currently available that contains all the suggested supplements **except** CoQ10 200 mg/day. This product, Conception XR for Men, is available at [www.conceptionxr.com](http://www.conceptionxr.com) (referral code **42430**). It can be used with CoQ10 200 mg/day to fulfill the recommended vitamin regime.

Also, FH PRO for men is available at www.fairhavenhealth.com (use discount code FHPRO for 10% off you order).

**Lubricants**

DO NOT USE saliva, KY Jelly, Astroglide, Surgilube, or any other over-the-counter lubricants. Natural lubrication is best.

**Dr. Jenkins recommends:**

1. A small amount of baby oil
2. Coconut oil
3. Preseed – this is available at [www.preseed.com](http://www.preseed.com).

No non-company data: Astroglide TTC, Sasmar Conceive Plus, BabyDance Fertility Lubricant (10% discount code - BABYDANCE), www.fairhavenhealth.com

Icifuq

Drug: \*\*\*Trimix

Injects: approx \*\*\*x/month

Dose: \*\*\* units

Rigidity: \*\*\*/10

Duration: \*\*\* mins

Misses: \*\*\*

Icitraining

**ICI Procedure**

Today the patient received an injection of Trimix (VI) \*\*\* units.

This was \*\*\*self\*\*\*given in the penile shaft. The results of this injection: \*\*\*% erection.

After 60 mins he was \*\*\*% rigid.

He required/didnot require reversal of his erection with 1 mL of Phenylephrine (1mg/mL) x \*\*\*. He was discharged at \*\*\*% rigidity

His next/home dose will be \*\*\* units.

This was done under the direction of Dr. Jenkins.

Iief6chart

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date | Duration Post Tx | Spont  EF | Spont  EFD | Oral Agent | Dose | Resp  EF | Oral EFD | ICI Agent | Dose | Peak Resp | Pen Rig  Duration | ICI EFD |
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Iiefefd

**Sexual Medicine Questionnaire**

Duration after surgery (months):  \*\*\*

**OVER THE PAST 4 WEEKS DURING SEXUAL STIMULATION (SELF OR PARTNER)**

Please fill in the scores in EACH box for EACH treatment:  NO MEDICATION, with a PILL.  If you have used a pill in the last month and with INJECTIONS if you are using injections.  Please place the score in each box and total the score at the end.

Please use the scale below for Questions 1-4

|  |  |  |  |
| --- | --- | --- | --- |
|  | Without Any Medication | With a Pill (Viagra, Cialis, Levitra) | With a Penile Injections |
| 1.  How often were you able to get an erection during sexual activity? | {HFHS AMB IIEF 7:28881} | {HFHS AMB IIEF 7:28881} | {HFHS AMB IIEF 7:28881} |
| 2.  When you had erections with sexual stimulation, **how often** were your erections hard enough for penetration? | {HFHS AMB IIEF 7:28881} | {HFHS AMB IIEF 7:28881} | {HFHS AMB IIEF 7:28881} |
| 3.  When you attempted sexual intercourse, **how often** were you able to penetrate (enter)? | {HFHS AMB IIEF 7:28881} | {HFHS AMB IIEF 7:28881} | {HFHS AMB IIEF 7:28881} |
| During sexual intercourse, **how often** were you able to maintain your erection after you had penetrated (entered) your partner? | {HFHS AMB IIEF 7:28881} | {HFHS AMB IIEF 7:28881} | {HFHS AMB IIEF 7:28881} |
| During sexual intercourse, **how difficult** was it to maintain your erection to complete intercourse? | {HFHS AMB IIEF 5:28879} | {HFHS AMB IIEF 5:28879} | {HFHS AMB IIEF 5:28879} |
| How do you rate your confidence that you could get and keep an erection? | {HFHS AMB IIEF 12:28885} | {HFHS AMB IIEF 12:28885} | {HFHS AMB IIEF 12:28885} |

Total:                                       \*\*\*                                \*\*\*                                \*\*\*

Use the grading system below:

**0/10                 Completely flaccid (soft)**

**6/10                 The first rigidity (hardness) that would permit penetration**

**10/10                Completely rigid (hard)**

1.  Without the use of medication (pill or injection) but with self-stimulation, how would you grade your erection hardness within the past 1 month?                         \*\*\*/10

2.  Without the use of medication (pill or injection) but with stimulation, by your partner, how would you grade your erection hardness within the past 1 month?       \*\*\*/10

3.  With the use of a pill (Viagra, Levitra, Cialis) with stimulation, how would you grade your erection hardness within the past 1 month?                                          \*\*\*/10

4.  If you are using pills, what medication are you using and at what dose?

{HFHS AMB VIAGRA/LEVITRA/CIALIS:28887}

5.  If you are using penis injections, what medications are you using and at what dose?

{HFHS AMB TRIMIX/BIMIX/PAPVERINE/CAVERJECT:28888}

6.  If you are using penile injections, how would you grade your erection hardness within the past 1 month?                                                                                           \*\*\*/10

7.  If you are using penis injections, how long would the erection last at penetration hardness (greater than or equal to a 6/10)?                                                  \*\*\* minutes

ILV

He presents today for #\*\*\* injection for Peyronie's disease.

Injections were given by Lawrence Jenkins, MD.

A dorsal penile nerve block was performed using 10 mL of 0.5% bupivicaine. After this took effect, a total of 10 mL of verapamil (10mg/5mL) was injected into the penile plaque using a 25 gauge needle.

Patient tolerated the procedure well. No active bleeding or bruising noted. Area wrapped in 2x2 gauze and 1 inch Coban. Patient instructed to leave dressing on for 4 hours, but to remove if there was difficulty urinating or the tip of the penis became painful/numb/blue.

Patient may resume use of penile traction device as directed in 24 hours.

Follow up in 2 weeks for ILV #\*\*\*

\*\*\*Follow up in 6weeks/3 months for curvature reassessment.

I personally performed or was physically present during the key portions of the procedure today.

Ilx1

He presents today for #1 (cycle #1\*\*\*) injection for Peyronie's disease.

Injections were given by Lawrence Jenkins, MD.

A total of 0.9 mg of Xiaflex was injected into the penile plaque using a 27 gauge needle.

Patient tolerated the procedure well. No active bleeding or bruising noted. Area wrapped in 2x2 gauze and 1 inch Coban. Patient instructed to leave dressing on for 24 hours, but to remove if there was difficulty urinating or the tip of the penis became painful/numb/blue.

Follow up in 1 weeks for ILX #2\*\*\*

He was reminded no sexual activity for 4 weeks.

**Today we used the medication from our stock\*\*\* supply and not pre-ordered.**

I personally performed or was physically present during the key portions of the procedure today.

Ilx2

He presents today for #2 (cycle #1\*\*\*) injection for Peyronie's disease.

Injections were given by Lawrence Jenkins, MD.

A total of 0.9 mg of Xiaflex was injected into the penile plaque using a 27 gauge needle.

Patient tolerated the procedure well. No active bleeding or bruising noted. Area wrapped in 2x2 gauze and 1 inch Coban. Patient instructed to leave dressing on for 24 hours, but to remove if there was difficulty urinating or the tip of the penis became painful/numb/blue.

Patient will start modeling as directed in 1-3 days.

Follow up in 6 weeks for ILX #3\*\*\*

He was reminded no sexual activity for 2 weeks.

**Today we used the medication from our stock\*\*\* supply and not pre-ordered.**

I personally performed or was physically present during the key portions of the procedure today.

Imtplan

1. Testosterone cypionate 100mg weekly, administer in evening

2. Testosterone free and total, estradiol, hgb/hematocrit, SHBG, and LH on the morning after his testosterone injection in 3 weeks

3. Testosterone free and total the week after his injection, on the morning of the day his next dose is due

4. If labs are appropriate, will have him return in 6 months with new labs

Infertilityplan

Infertility - initial visit

-obtain hormone labs: Total and Free testosterone, LH, Estradiol, FSH

-obtain 2 semen analyses 2-4 wks apart and 3-4 days of abstinence for each one

Ippopcolopenoscrotal

**PREOPERATIVE DIAGNOSIS:** Erectile dysfunction

**POSTOPERATIVE DIAGNOSIS:** Erectile dysfunction

**PROCEDURE:** Insertion of multi-component penile implant (54405) utilizing “no-touch” technique

**SURGEON:** Lawrence Jenkins, MD

**ASSISTANT:** \*\*\*

**ANESTHESIA:** General

**EBL:** 50 mL

**DRAINS:** \*\*\*

IMPLANT: Coloplast Titan Genesis pump

**INDICATIONS:** The patient is a \*\*\*-year-old male with a history of ED who has failed conservative management.

We discussed penile implant surgery given his ED. We had a discussion regarding penile implant surgery, its pros and cons and risks, and benefits including an approximately 2% infection rate and 15% re-operation rate within the first decade after primary implantation. He was counseled regarding 2-piece or a 3-piece device. He opted for the latter. The patient signed an informed consent form for the hospital and verbalized understanding of the risks, potential complications, and outcomes and requested to proceed with the operation.

**PRE-OPERATIVE PREPARATION:** The patient was seen in the weeks before surgery.  He had his pre-operative laboratory testing performed, had a urine specimen collected for culture and sensitivity.  He was instructed then to use Chlorhexidine scrub once per day while showering for the 7 days before surgery.  He was also instructed to take Bactrim DS 1 tab PO BID for the 48 hours before surgery.  On the morning of surgery, he was admitted to the pre-operative holding area having been NPO post-midnight. He had an intravenous line commenced and had the administration of Gentamicin at 5mg/kg as well as 600mg of Linezolid.

**OPERATION:** The patient was brought into the operating room, he had the administration of general anesthesia, and the patient was placed on the OR table with his legs in a "frog-like position" with the knees slightly bent outward and feet touching on the midline.

**SKIN PREPARATION:** The lower inguinal and penoscrotal area was shaved completely and prepped with a complete skin cleansing with two Chloraprep (Chlorhexidine/70% alcohol) applicators. The alcohol was allowed to evaporate for 3 minutes, and the patient was subsequently draped in the routine sterile fashion.

He was given bilateral pudendal blocks with 10 mL in each peri-crural space using a mixture of 0.5% ropivicaine plain – 30 mL/ dexamethasone – 4mg (1mL).

He was then draped in the standard multi-layer fashion. The penis and scrotum were then delivered through a small fenestration in the extremity drape. Throughout the procedure, copious amounts antibiotic irrigation (vancomycin/gentamicin) solution was used, and for exposure, a metal Lonestar retractor with yellow elastic stays were utilized.

**INCISION:** A vertical scrotal incision was made straddling the penoscrotal junction approximating 5 cm in length.  This was carried down to subcutaneous layers using a combination of cautery and blunt dissection until the tunica albuginea was clearly identified on both sides of the urethra.  Four blunt yellow hooks were utilized to maintain the skin incision open by being secured to the Scott retractor.

**NO-TOUCH TECHNIQUE OF SKIN ISOLATION**:  At this point, surgical gloves, instruments, and sponges that had touched the patient's skin were removed and isolated from the surgical field. New sterile gloves were utilized to place the loose transparent surgical drape over the entire surgical field. A small opening was made in the drape exactly over the skin incision. The drape was then secured to the edges of the surgical wound with an additional four blunt yellow hooks also secured to the Scott retractor. The skin was thus completely covered, and further dissection and complete insertion of the prosthesis device could be performed through the aperture of the transparent drape without direct contact with the patient's skin.

**CORPORAL DILATION AND SIZING:** The corporal bodies were incised for a length of approximately 1 inch one finger-breadth lateral to the urethral margin, between 2-0 PDS sutures on either side.  Dilation was conducted with a Dilamezinsert dilator with uneventful dilation into the crus and the glans penis for both corporal bodies. No crural perforation or urethral perforation was encountered. Each corpus cavernosum was measured independently utilizing the blunt Dilamezinsert. Both the right and left corpora were measured two times alternating sides between measurements. A total corporal length was measured at \*\*\* cm on bilaterally. After the corpora had been measured a second time, a decision was made to use an \*\*\* cm Coloplast Titan, Genesis pump, prosthesis with \*\*\* cm rear tip extenders. The cylinders were coated in a rifampin /gentamicin mixture.

**CYLINDER PLACEMENT:** At this point, the prosthesis was brought into the field and delivered from its sterile package. The prosthesis was prepared for insertion by purging all air out of the system. The device was then sized properly by adding the correct size of rear tip extenders. The cylinders were placed in the standard fashion using a Keith needle/Furlow passer system. The cylinders were lined up so that the tubing from each cylinder to the pump did not cross over each other. The cylinders were nicely seated within each corporal body.

**SURROGATE SALINE TEST:** Before closure of the corporotomy a surrogate test was performed with a filled 60 mL syringe. When fully pumped the distal tip of each cylinder reached the glans penis. The glans penis was well supported. Also, no effacement of the groove between the glans penis and penile shaft was noted and no overriding of cylinders identified. The prosthesis was appropriately sized with an excellent erection and no evidence of under or over sizing. With detumescence, minimal folding of cylinders was noted indicating that the cylinders again were appropriately sized. It took \*\*\* mL of saline to inflate the device fully.

**CLOSURE OF THE CORPOROTOMIES:** The prosthesis was deflated and the traction suture from each cylinder tip secured to the Scott retractor with mosquito clamps. The corporotomies were then closed with the 2-0 PDS preplaced sutures. Each corporotomy was then examined for hemostasis and felt to be grossly watertight.

**\*\*\*PENILE MODELING**: The cylinders were inflated to the maximum. Rubber-shod clamps were placed on the cylinder tubing to protect the pump. While holding the corporotomies, the penis was then bent hard in the direction opposite to the curvature for 90 seconds. After 90 seconds, the clamps were removed, and we were able to inflate the prosthesis a few more pumps due to stretching of the Peyronie’s plaque. The penile curvature was decreased and was close to 20° curvature or less.

**RESERVOIR SPACE CREATION:** The bladder was completely emptied via the Foley catheter.  Through the incision, using the index finger, a tunnel was fashioned between the inguinal cord and the base of the penis.  The left external ring was subsequently easily identified by palpation. Blunt dissection with the assistance of a nasal speculum was used to make a small opening in the floor of the left inguinal canal.  The opening was further dilated to allow the operator’s index finger.  The operator’s finger was then replaced with the long nasal speculum.  A \*\*\*75 mL Coloplast Cloverleaf reservoir was placed in the left pre-vesical space and filled with \*\*\* mL of normal saline. After being assured that the reservoir was without back-pressure, we turned our attention to the final part of the procedure.

**PUMP PLACEMENT:** The scrotal pump was placed in a pouch in a midline dependent position.  The pouch was fashioned with finger dissection and once the pump was placed the Dartos layer was closed with 3-0 Vicryl suture above the pump and the tubing secured deep in the wound, great care being taken not to violate the device or the tubing. Following this, the redundant tubing was excised and the reservoir and pump tubing were connected in a standard fashion with the connectors in the assembly kit. Great care was taken not to have the tubing cross over each other.

**PROSTHESIS CYCLING:** The pump was activated and deactivated several times. Each time the penis was examined and cylinder size and erection reassessed. Good cosmesis of the flaccid and erect penis was present. At this point, the device was fully inflated and deflated. Upon inflation, there was a straight rigid erection with the tips present within the glans penis. Antibiotic irrigation was used to wash out the scrotum.

**INCISION CLOSURE:** Following the achievement of complete hemostasis and final irrigation with antibiotic solution, the Buck’s fascia was closed with interrupted 3/0 Vicryl suture. The skin was closed with 4/0 Monocryl in an interrupted fashion. The incisions were infiltrated with the mixture of using a mixture of 0.5% ropivicaine plain – 30 mL/dexamethasone – 4mg. A Xeroform dressing was applied over the wound with dry sterile mummy wrap dressing over this, and a fluff gauze pads were unraveled acting as a compression dressing within a scrotal support.

The patient was awake in the operating room. He was transferred to the recovery room in stable condition.

I, Lawrence Jenkins MD, performed and was present for the entire procedure from the initial incision to the closing of the skin.

IPPdiscussion

I had a long discussion with this patient about an IPP placement. The risk were explained. The infection rate is about 2 - 3%. If an infection were to occur, the prosthesis would need to be removed. Depending on the the severity of the infection, a prosthesis may or may not be able to be replaced in the same setting. Delayed replacement of a prosthesis is more difficult and is occasionally not possible. Like any other mechanical device, mechanical dysfunction can occur. If this were to happen, revision surgery would be necessary.

Like any other surgical procedure, injury to surrounding organs is possible during the surgery. Known surrounding organ injuries include the urethra and the bladder. If a urethral injury were to occur, the procedure would need to be abandoned until the urethra has healed.

Cardiovascular risks such as an MI or PE are not uncommon to any surgical procedure requiring general or regional anesthesia. \*\*\*I have asked this patient to see OPAC prior to surgery. All questions were answered and patient wants to proceed in this manner.

IPPopamsinfrapubic

**PREOPERATIVE DIAGNOSIS:** Erectile dysfunction

**POSTOPERATIVE DIAGNOSIS:** Erectile dysfunction

**PROCEDURE:** Insertion of multi-component penile implant (54405) utilizing “no-touch” technique

**SURGEON:** Lawrence Jenkins, MD

**ASSISTANT:** \*\*\*

**ANESTHESIA:** General

**EBL:** 50 mL

**DRAINS:** 15 Fr round JP

**IMPLANT**: AMS CX\*\*\* MS Pump

**INDICATIONS:** The patient is a @AGE@-year-old male with a history of ED who has failed conservative management.

We discussed penile implant surgery given his ED. We had a discussion regarding penile implant surgery, its pros and cons and risks, and benefits including an approximately 2% infection rate and 15% re-operation rate within the first decade after primary implantation. He was counseled regarding 2-piece or a 3-piece device. He opted for the latter. The patient signed an informed consent form for the hospital and verbalized understanding of the risks, potential complications, and outcomes and requested to proceed with the operation.

**PRE-OPERATIVE PREPARATION:** The patient was seen in the weeks before surgery.  He had his pre-operative laboratory testing performed, had a urine specimen collected for culture and sensitivity.  He was instructed then to use Chlorhexidine scrub once per day while showering for the 7 days before surgery.  He was also instructed to take Bactrim DS 1 tab PO BID for the 48 hours before surgery.  On the morning of surgery, he was admitted to the pre-operative holding area having been NPO post-midnight. He had an intravenous line commenced and had the administration of Gentamicin at 5mg/kg as well as Vancomycin.

**OPERATION:** The patient was brought into the operating room, he had the administration of general anesthesia, and the patient was placed on the OR table with his legs in a "frog-like position" with the knees slightly bent outward and feet touching on the midline.

**SKIN PREPARATION:** The lower inguinal and penoscrotal area was shaved completely and prepped with a complete skin cleansing with two Chloraprep (Chlorhexidine/70% alcohol) applicators. The alcohol was allowed to evaporate for 3 minutes, and the patient was subsequently draped in the routine sterile fashion.

He was given bilateral pudendal blocks with 10 mL in each peri-crural space using a mixture of 0.5% ropivicaine plain – 30 mL/ dexamethasone – 4mg (1mL).

He was then draped in the standard multi-layer fashion. Throughout the procedure, copious amounts antibiotic irrigation (vancomycin/gentamicin/amphotericin B) solution was used, and for exposure, a Lonestar retractor with yellow elastic stays were utilized.

**INCISION:**  An artificial erection was performed using a 21-gauge butterfly needle with normal saline, demonstrating no significant pathology. An infrapubic incision was made, extending approximately 2-3 cm across the infrapubic area, making sure to stay away from the penile pubic junction. Once dissection was carried down to the level of the corporal bodies bilaterally, making sure to spare the superficial epigastrics lateral to this dissection. Once down to the corpora we setup for the no-touch technique.

**NO-TOUCH TECHNIQUE OF SKIN ISOLATION**:  At this point, surgical gloves, instruments, and sponges that had touched the patient's skin were removed and isolated from the surgical field. New sterile gloves were utilized to place the loose transparent surgical drape over the entire surgical field. A small opening was made in the drape exactly over the skin incision. The drape was then secured to the edges of the surgical wound with an additional four blunt yellow hooks also secured to the Scott retractor. The skin was thus completely covered, and further dissection and complete insertion of the prosthesis device could be performed through the aperture of the transparent drape without direct contact with the patient's skin.

**CORPORAL DILATION AND SIZING:** 2-0 Monocryl stay sutures were placed bilaterally making sure the sutures were placed as lateral as possible, on each individual corpus clearly away from the neurovascular bundles. Bilateral corporotomies were performed measuring 1.5 cm. Dilation was conducted with a Dilamezinsert dilator with uneventful dilation into the crus and the glans penis for both corporal bodies. No crural perforation or urethral perforation was encountered. Each corpus cavernosum was measured independently utilizing the blunt Dilamezinsert. Both the right and left corpora were measured two times alternating sides between measurements. A total corporal length was measured at \*\*\* cm on bilaterally. After the corpora had been measured a second time, a decision was made to use an \*\*\* cm AMS 700 CX, MS pump, prosthesis with \*\*\* cm rear tip extenders.

**RESERVOIR SPACE CREATION:** The bladder was completely emptied via the Foley catheter.\*\*\*  Through the incision, using the index finger, a tunnel was fashioned between the inguinal cord and the base of the penis.  The {left/right:311354} external ring was subsequently easily identified by palpation. Blunt dissection was used to make a small opening in the floor of the {left/right:311354} inguinal canal.  The opening was further dilated to allow the operator’s index finger and a nasal speculum. A {AMS reservoir:29273} reservoir was placed in the {left/right:311354} {Reservoir location:29274} space and filled with \*\*\* mL of normal saline.

**CYLINDER PLACEMENT:** At this point, the prosthesis was brought into the field and delivered from its sterile package. The prosthesis was prepared for insertion by purging all air out of the system. The device was then sized properly by adding the correct size of rear tip extenders. The cylinders were placed in the standard fashion using a Keith needle/Furlow passer system. The cylinders were lined up so that the tubing from each cylinder to the pump did not cross over each other. The cylinders were nicely seated within each corporal body.

**SURROGATE SALINE TEST:** Before closure of the corporotomy a surrogate test was performed with a filled 60 mL syringe. When fully pumped the distal tip of each cylinder reached the glans penis. Also, no effacement of the groove between the glans penis and penile shaft was noted and no overriding of cylinders identified. The prosthesis was appropriately sized with an excellent erection and no evidence of under or over sizing. With detumescence, minimal folding of cylinders was noted indicating that the cylinders again were appropriately sized. It took \*\*\* mL of saline to inflate the device fully.

**\*\*\*PENILE MODELING**: The cylinders were inflated to the maximum. Rubber-shod clamps were placed on the cylinder tubing to protect the pump. While holding the corporotomies, the penis was then bent hard in the direction opposite to the curvature for 90 seconds. After 90 seconds, the clamps were removed, and we were able to inflate the prosthesis a few more pumps due to stretching of the Peyronie’s plaque. The penile curvature was decreased and was close to 20° curvature or less.

**CLOSURE OF THE CORPOROTOMIES:** The prosthesis was deflated and the corporotomies were then closed with the 2-0 Monocryl preplaced sutures. Each corporotomy was then examined for hemostasis and felt to be grossly watertight.

**PUMP PLACEMENT:** A nasal speculum was then utilized to develop the midline posterior dependent pouch in the scrotum after first perforating Colles fascia with the nasal speculum and then developing the space with one spread of the nasal speculum. The pump was then placed in the most dependent portion of the scrotum along the midline. The pump was then pulled up in order to allow for any redundancy in the tubing to be non-existent after the connections were made. The redundant tubing was excised and the reservoir and pump tubing were connected in a standard fashion with the connectors in the assembly kit. The pump was then finally pulled down to the most dependent portion of the scrotum without any difficulty.

**PROSTHESIS CYCLING:** The pump was activated and deactivated, the penis was examined and cylinder size and erection reassessed. Good cosmesis of the flaccid and erect penis was present. Antibiotic irrigation was used to wash out the incision.

**INCISION CLOSURE:**  A 15 Fr round hubless Jackson-Pratt drain was brought out through a separate stab wound lateral to the incision through the surgical field into the scrotum. The wound was irrigated with copious amounts of antibiotic fluid throughout the procedure. Following the achievement of complete hemostasis and final irrigation with antibiotic solution, the fascia was closed in two layers with 3-0 Vicryl in a running fashion. The skin was closed with 4-0 Monocryl in an interrupted fashion. The incisions were infiltrated with the mixture of using a mixture of 0.5% ropivicaine plain – 30 mL/ dexamethasone – 4mg. Dermabond was applied over the wound, dry sterile gauze mummy wrap dressing was applied around the penis and scrotum, and fluff gauze pads were unraveled acting as extra support within a scrotal support.

All surgical counts were correct at the end of the procedure. The patient was awakened in the operating room. He was transferred to the recovery room in stable condition.

I, Lawrence Jenkins MD, performed and was present for the entire procedure from the initial incision to the closing of the skin.

Ippopamssubcoronal

**PREOPERATIVE DIAGNOSIS:** Erectile dysfunction

**POSTOPERATIVE DIAGNOSIS:** Erectile dysfunction

**PROCEDURE:** Insertion of multi-component penile implant (54405) utilizing “no-touch” technique

**SURGEON:** Lawrence Jenkins, MD

**ASSISTANT:** \*\*\*

**ANESTHESIA:** General

**EBL:** 50 mL

**DRAINS:** 15 Fr round JP

**IMPLANT**: AMS CX\*\*\* MS Pump

**INDICATIONS:** The patient is a @AGE@-year-old male with a history of ED who has failed conservative management.

We discussed penile implant surgery given his ED. We had a discussion regarding penile implant surgery, its pros and cons and risks, and benefits including an approximately 2% infection rate and 15% re-operation rate within the first decade after primary implantation. He was counseled regarding 2-piece or a 3-piece device. He opted for the latter. The patient signed an informed consent form for the hospital and verbalized understanding of the risks, potential complications, and outcomes and requested to proceed with the operation.

**PRE-OPERATIVE PREPARATION:** The patient was seen in the weeks before surgery.  He had his pre-operative laboratory testing performed, had a urine specimen collected for culture and sensitivity.  He was instructed then to use Chlorhexidine scrub once per day while showering for the 7 days before surgery.  He was also instructed to take Bactrim DS 1 tab PO BID for the 48 hours before surgery.  On the morning of surgery, he was admitted to the pre-operative holding area having been NPO post-midnight. He had an intravenous line commenced and had the administration of Gentamicin at 5mg/kg as well as Vancomycin.

**OPERATION:** The patient was brought into the operating room, he had the administration of general anesthesia, and the patient was placed on the OR table with his legs in a "frog-like position" with the knees slightly bent outward and feet touching on the midline.

**SKIN PREPARATION:** The lower inguinal and penoscrotal area was shaved completely and prepped with a complete skin cleansing with two Chloraprep (Chlorhexidine/70% alcohol) applicators. The alcohol was allowed to evaporate for 3 minutes, and the patient was subsequently draped in the routine sterile fashion.

He was given bilateral pudendal blocks with 10 mL in each peri-crural space using a mixture of 0.5% ropivicaine plain – 30 mL/ dexamethasone – 4mg (1mL).

He was then draped in the standard multi-layer fashion. The penis and scrotum were then delivered through a small fenestration in the extremity drape. Throughout the procedure, copious amounts antibiotic irrigation (vancomycin/gentamicin) solution was used, and for exposure, a metal Lonestar retractor with yellow elastic stays were utilized.

**INCISION:** A vertical scrotal incision was made straddling the penoscrotal junction approximating 5 cm in length.  This was carried down to subcutaneous layers using a combination of cautery and blunt dissection until the tunica albuginea was clearly identified on both sides of the urethra.  Three blunt yellow hooks were utilized to maintain the skin incision open by being secured to the Scott retractor, as well as one sharp blue hook securing the meatus.

**NO-TOUCH TECHNIQUE OF SKIN ISOLATION**:  At this point, surgical gloves, instruments, and sponges that had touched the patient's skin were removed and isolated from the surgical field. New sterile gloves were utilized to place the loose transparent surgical drape over the entire surgical field. A small opening was made in the drape exactly over the skin incision. The drape was then secured to the edges of the surgical wound with an additional four blunt yellow hooks also secured to the Scott retractor. The skin was thus completely covered, and further dissection and complete insertion of the prosthesis device could be performed through the aperture of the transparent drape without direct contact with the patient's skin.

**CORPORAL DILATION AND SIZING:** The corporal bodies were incised for a length of approximately 1 inch one finger-breadth lateral to the urethral margin, between 2-0 Maxon sutures on either side.  Dilation was conducted with a Dilamezinsert dilator with uneventful dilation into the crus and the glans penis for both corporal bodies. No crural perforation or urethral perforation was encountered. Each corpus cavernosum was measured independently utilizing the blunt Dilamezinsert. Both the right and left corpora were measured two times alternating sides between measurements. A total corporal length was measured at \*\*\* cm on bilaterally. After the corpora had been measured a second time, a decision was made to use an \*\*\* cm AMS 700 CX, MS pump, prosthesis with \*\*\* cm rear tip extenders.

**CYLINDER PLACEMENT:** At this point, the prosthesis was brought into the field and delivered from its sterile package. The prosthesis was prepared for insertion by purging all air out of the system. The device was then sized properly by adding the correct size of rear tip extenders. The cylinders were placed in the standard fashion using a Keith needle/Furlow passer system. The cylinders were lined up so that the tubing from each cylinder to the pump did not cross over each other. The cylinders were nicely seated within each corporal body.

**SURROGATE SALINE TEST:** Before closure of the corporotomy a surrogate test was performed with a filled 60 mL syringe. When fully pumped the distal tip of each cylinder reached the glans penis. The glans penis was well supported. Also, no effacement of the groove between the glans penis and penile shaft was noted and no overriding of cylinders identified. The prosthesis was appropriately sized with an excellent erection and no evidence of under or over sizing. With detumescence, minimal folding of cylinders was noted indicating that the cylinders again were appropriately sized. It took \*\*\* mL of saline to inflate the device fully.

**CLOSURE OF THE CORPOROTOMIES:** The prosthesis was deflated and the traction suture from each cylinder tip secured to the Scott retractor with mosquito clamps. The corporotomies were then closed with the 2-0 PDS preplaced sutures. Each corporotomy was then examined for hemostasis and felt to be grossly watertight.

**\*\*\*PENILE MODELING**: The cylinders were inflated to the maximum. Rubber-shod clamps were placed on the cylinder tubing to protect the pump. While holding the corporotomies, the penis was then bent hard in the direction opposite to the curvature for 90 seconds. After 90 seconds, the clamps were removed, and we were able to inflate the prosthesis a few more pumps due to stretching of the Peyronie’s plaque. The penile curvature was decreased and was close to 20° curvature or less.

**RESERVOIR SPACE CREATION:** The bladder was completely emptied via the Foley catheter.  Through the incision, using the index finger, a tunnel was fashioned between the inguinal cord and the base of the penis.  The left external ring was subsequently easily identified by palpation. Blunt dissection was used to make a small opening in the floor of the left inguinal canal.  The opening was further dilated to allow the operator’s index finger.   A \*\*\*100 mL AMS Conceal\*\*\* reservoir was placed in the left pre-vesical space and filled with \*\*\* mL of normal saline. After being assured that the reservoir was without back-pressure, we turned our attention to the final part of the procedure.

**PUMP PLACEMENT:** The scrotal pump was placed in a pouch in a midline dependent position.  The pouch was fashioned with finger dissection and once the pump was placed the Dartos layer was closed with 3-0 Vicryl suture above the pump and the tubing secured deep in the wound, great care being taken not to violate the device or the tubing. Following this, the redundant tubing was excised and the reservoir and pump tubing were connected in a standard fashion with the connectors in the assembly kit. Great care was taken not to have the tubing cross over each other.

**PROSTHESIS CYCLING:** The pump was activated and deactivated several times. Each time the penis was examined and cylinder size and erection reassessed. Good cosmesis of the flaccid and erect penis was present. At this point, the device was fully inflated and deflated. Upon inflation, there was a straight rigid erection with the tips present within the glans penis. Antibiotic irrigation was used to wash out the scrotum.

**INCISION CLOSURE:** Following the achievement of complete hemostasis and final irrigation with antibiotic solution, the Buck’s fascia was closed with interrupted 3-0 Vicryl suture. We placed a 15 Fr round JP drain in the scrotum with the exit in the groin. The skin was closed with 4-0 Monocryl in an interrupted fashion. The incisions were infiltrated with the mixture of using a mixture of 0.5% ropivicaine plain – 30 mL/ dexamethasone – 4mg. A Xeroform dressing was applied over the wound with dry sterile mummy wrap dressing over this, and a fluff gauze pads were unraveled acting as a compression dressing within a scrotal support.

The patient was awake in the operating room. He was transferred to the recovery room in stable condition.

I, Lawrence Jenkins MD, performed and was present for the entire procedure from the initial incision to the closing of the skin.

Ippopamspenoscrotal

**PREOPERATIVE DIAGNOSIS:** Erectile dysfunction

**POSTOPERATIVE DIAGNOSIS:** Erectile dysfunction

**PROCEDURE:** Insertion of multi-component penile implant (54405) utilizing “no-touch” technique

**SURGEON:** Lawrence Jenkins, MD

**ASSISTANT:** \*\*\*

**ANESTHESIA:** General

**EBL:** 50 mL

**DRAINS:** 15 Fr round JP

**IMPLANT**: AMS CX\*\*\* MS Pump

**INDICATIONS:** The patient is a @AGE@-year-old male with a history of ED who has failed conservative management.

We discussed penile implant surgery given his ED. We had a discussion regarding penile implant surgery, its pros and cons and risks, and benefits including an approximately 2% infection rate and 15% re-operation rate within the first decade after primary implantation. He was counseled regarding 2-piece or a 3-piece device. He opted for the latter. The patient signed an informed consent form for the hospital and verbalized understanding of the risks, potential complications, and outcomes and requested to proceed with the operation.

**PRE-OPERATIVE PREPARATION:** The patient was seen in the weeks before surgery.  He had his pre-operative laboratory testing performed, had a urine specimen collected for culture and sensitivity.  He was instructed then to use Chlorhexidine scrub once per day while showering for the 7 days before surgery.  He was also instructed to take Bactrim DS 1 tab PO BID for the 48 hours before surgery.  On the morning of surgery, he was admitted to the pre-operative holding area having been NPO post-midnight. He had an intravenous line commenced and had the administration of Gentamicin at 5mg/kg as well as Vancomycin.

**OPERATION:** The patient was brought into the operating room, he had the administration of general anesthesia, and the patient was placed on the OR table with his legs in a "frog-like position" with the knees slightly bent outward and feet touching on the midline.

**SKIN PREPARATION:** The lower inguinal and penoscrotal area was shaved completely and prepped with a complete skin cleansing with two Chloraprep (Chlorhexidine/70% alcohol) applicators. The alcohol was allowed to evaporate for 3 minutes, and the patient was subsequently draped in the routine sterile fashion.

He was given bilateral pudendal blocks with 10 mL in each peri-crural space using a mixture of 0.5% ropivicaine plain – 30 mL/ dexamethasone – 4mg (1mL).

He was then draped in the standard multi-layer fashion. The penis and scrotum were then delivered through a small fenestration in the extremity drape. Throughout the procedure, copious amounts antibiotic irrigation (vancomycin/gentamicin) solution was used, and for exposure, a metal Lonestar retractor with yellow elastic stays were utilized.

**INCISION:** A vertical scrotal incision was made straddling the penoscrotal junction approximating 5 cm in length.  This was carried down to subcutaneous layers using a combination of cautery and blunt dissection until the tunica albuginea was clearly identified on both sides of the urethra.  Three blunt yellow hooks were utilized to maintain the skin incision open by being secured to the Scott retractor, as well as one sharp blue hook securing the meatus.

**NO-TOUCH TECHNIQUE OF SKIN ISOLATION**:  At this point, surgical gloves, instruments, and sponges that had touched the patient's skin were removed and isolated from the surgical field. New sterile gloves were utilized to place the loose transparent surgical drape over the entire surgical field. A small opening was made in the drape exactly over the skin incision. The drape was then secured to the edges of the surgical wound with an additional four blunt yellow hooks also secured to the Scott retractor. The skin was thus completely covered, and further dissection and complete insertion of the prosthesis device could be performed through the aperture of the transparent drape without direct contact with the patient's skin.

**CORPORAL DILATION AND SIZING:** The corporal bodies were incised for a length of approximately 1 inch one finger-breadth lateral to the urethral margin, between 2-0 Maxon sutures on either side.  Dilation was conducted with a Dilamezinsert dilator with uneventful dilation into the crus and the glans penis for both corporal bodies. No crural perforation or urethral perforation was encountered. Each corpus cavernosum was measured independently utilizing the blunt Dilamezinsert. Both the right and left corpora were measured two times alternating sides between measurements. A total corporal length was measured at \*\*\* cm on bilaterally. After the corpora had been measured a second time, a decision was made to use an \*\*\* cm AMS 700 CX, MS pump, prosthesis with \*\*\* cm rear tip extenders.

**CYLINDER PLACEMENT:** At this point, the prosthesis was brought into the field and delivered from its sterile package. The prosthesis was prepared for insertion by purging all air out of the system. The device was then sized properly by adding the correct size of rear tip extenders. The cylinders were placed in the standard fashion using a Keith needle/Furlow passer system. The cylinders were lined up so that the tubing from each cylinder to the pump did not cross over each other. The cylinders were nicely seated within each corporal body.

**SURROGATE SALINE TEST:** Before closure of the corporotomy a surrogate test was performed with a filled 60 mL syringe. When fully pumped the distal tip of each cylinder reached the glans penis. The glans penis was well supported. Also, no effacement of the groove between the glans penis and penile shaft was noted and no overriding of cylinders identified. The prosthesis was appropriately sized with an excellent erection and no evidence of under or over sizing. With detumescence, minimal folding of cylinders was noted indicating that the cylinders again were appropriately sized. It took \*\*\* mL of saline to inflate the device fully.

**CLOSURE OF THE CORPOROTOMIES:** The prosthesis was deflated and the traction suture from each cylinder tip secured to the Scott retractor with mosquito clamps. The corporotomies were then closed with the 2-0 PDS preplaced sutures. Each corporotomy was then examined for hemostasis and felt to be grossly watertight.

**\*\*\*PENILE MODELING**: The cylinders were inflated to the maximum. Rubber-shod clamps were placed on the cylinder tubing to protect the pump. While holding the corporotomies, the penis was then bent hard in the direction opposite to the curvature for 90 seconds. After 90 seconds, the clamps were removed, and we were able to inflate the prosthesis a few more pumps due to stretching of the Peyronie’s plaque. The penile curvature was decreased and was close to 20° curvature or less.

**RESERVOIR SPACE CREATION:** The bladder was completely emptied via the Foley catheter.  Through the incision, using the index finger, a tunnel was fashioned between the inguinal cord and the base of the penis.  The left external ring was subsequently easily identified by palpation. Blunt dissection was used to make a small opening in the floor of the left inguinal canal.  The opening was further dilated to allow the operator’s index finger.   A \*\*\*100 mL AMS Conceal\*\*\* reservoir was placed in the left pre-vesical space and filled with \*\*\* mL of normal saline. After being assured that the reservoir was without back-pressure, we turned our attention to the final part of the procedure.

**PUMP PLACEMENT:** The scrotal pump was placed in a pouch in a midline dependent position.  The pouch was fashioned with finger dissection and once the pump was placed the Dartos layer was closed with 3-0 Vicryl suture above the pump and the tubing secured deep in the wound, great care being taken not to violate the device or the tubing. Following this, the redundant tubing was excised and the reservoir and pump tubing were connected in a standard fashion with the connectors in the assembly kit. Great care was taken not to have the tubing cross over each other.

**PROSTHESIS CYCLING:** The pump was activated and deactivated several times. Each time the penis was examined and cylinder size and erection reassessed. Good cosmesis of the flaccid and erect penis was present. At this point, the device was fully inflated and deflated. Upon inflation, there was a straight rigid erection with the tips present within the glans penis. Antibiotic irrigation was used to wash out the scrotum.

**INCISION CLOSURE:** Following the achievement of complete hemostasis and final irrigation with antibiotic solution, the Buck’s fascia was closed with interrupted 3-0 Vicryl suture. We placed a 15 Fr round JP drain in the scrotum with the exit in the groin. The skin was closed with 4-0 Monocryl in an interrupted fashion. The incisions were infiltrated with the mixture of using a mixture of 0.5% ropivicaine plain – 30 mL/ dexamethasone – 4mg. A Xeroform dressing was applied over the wound with dry sterile mummy wrap dressing over this, and a fluff gauze pads were unraveled acting as a compression dressing within a scrotal support.

The patient was awake in the operating room. He was transferred to the recovery room in stable condition.

I, Lawrence Jenkins MD, performed and was present for the entire procedure from the initial incision to the closing of the skin.

Ippopmalleable

**PREOPERATIVE DIAGNOSIS:** Erectile dysfunction

**POSTOPERATIVE DIAGNOSIS:** Erectile dysfunction

**PROCEDURE:** Insertion of single-component penile implant

**SURGEON:** Lawrence Jenkins, MD

**ASSISTANT:** \*\*\*

**ANESTHESIA:** General

**EBL:** 50 mL

**DRAINS:** none

**IMPLANT**: Boston Scientific AMS Tactra

**INDICATIONS:** The patient is a @AGE@-year-old male with a history of ED who has failed conservative management.

We discussed penile implant surgery given his ED. We had a discussion regarding penile implant surgery, its pros and cons and risks, and benefits including an approximately 2% infection rate and 15% re-operation rate within the first decade after primary implantation. He was counseled regarding 2-piece, a 3-piece device, or a malleable device. He opted for the latter. The patient signed an informed consent form for the hospital and verbalized understanding of the risks, potential complications, and outcomes and requested to proceed with the operation.

**PRE-OPERATIVE PREPARATION:** The patient was seen in the weeks before surgery.  He had his pre-operative laboratory testing performed, had a urine specimen collected for culture and sensitivity.  He was instructed then to use Chlorhexidine scrub once per day while showering for the 7 days before surgery.  He was also instructed to take Bactrim DS 1 tab PO BID for the 48 hours before surgery.  On the morning of surgery, he was admitted to the pre-operative holding area having been NPO post-midnight. He had an intravenous line commenced and had the administration of Gentamicin at 5mg/kg as well as Vancomycin.

**OPERATION:** The patient was brought into the operating room, he had the administration of general anesthesia, and the patient was placed on the OR table with his legs in a "frog-like position" with the knees slightly bent outward and feet touching on the midline.

**SKIN PREPARATION:** The lower inguinal and penoscrotal area was shaved completely and prepped with a complete skin cleansing with two Chloraprep (Chlorhexidine/70% alcohol) applicators. The alcohol was allowed to evaporate for 3 minutes, and the patient was subsequently draped in the routine sterile fashion.

He was given bilateral pudendal blocks with 10 mL in each peri-crural space using a mixture of 0.5% ropivicaine plain – 30 mL/ dexamethasone – 4mg (1mL).

He was then draped in the standard multi-layer fashion. The penis and scrotum were then delivered through a small fenestration in the extremity drape. Throughout the procedure, copious amounts antibiotic irrigation (vancomycin/gentamicin) solution was used.

**INCISION:** A vertical scrotal incision was made straddling the penoscrotal junction approximating 5 cm in length.  This was carried down to subcutaneous layers using a combination of cautery and blunt dissection until the tunica albuginea was clearly identified on both sides of the urethra.

**CORPORAL DILATION AND SIZING:** The corporal bodies were incised for a length of approximately 5 cms one finger-breadth lateral to the urethral margin, between 2-0 Maxon sutures on either side.  Dilation was conducted with a hegar disposable dilator with uneventful dilation into the crus and the glans penis for both corporal bodies. No crural perforation or urethral perforation was encountered. Each corpus cavernosum was measured independently utilizing the dilator. Both the right and left corpora were measured two times alternating sides between measurements. A total corporal length was measured at \*\*\* cm bilaterally. After the corpora had been measured a second time, a decision was made to use a \*\*\* cm diameter AMS Tactra malleable implant with 0 cm rear tip extenders. The cylinders were trimmed to \*\*\* cm on the right and \*\*\* cm on the left.

**CYLINDER PLACEMENT:** At this point, the prosthesis was brought into the field and delivered from its sterile package. The prosthesis was prepared for insertion. The device was then sized properly by adding the correct size of rear tip extenders. The cylinders were placed in the standard fashion.The cylinders were nicely seated within each corporal body.

**CLOSURE OF THE CORPOROTOMIES:**  The corporotomies were then closed with the 2-0 Maxon running sutures. Each corporotomy was then examined for hemostasis and felt to be grossly watertight. Antibiotic irrigation was used to wash out the scrotum.

**INCISION CLOSURE:** Following the achievement of complete hemostasis and final irrigation with antibiotic solution, the Buck’s fascia was closed with interrupted 3-0 Vicryl suture. The skin was closed with 4-0 Monocryl in an interrupted fashion. The incisions were infiltrated with the mixture of using a mixture of 0.5% ropivicaine plain – 30 mL/ dexamethasone – 4mg. A Xeroform dressing was applied over the wound with dry sterile mummy wrap dressing over this, and a fluff gauze pads were unraveled acting as a compression dressing within a scrotal support.

The patient was awake in the operating room. He was transferred to the recovery room in stable condition.

I, Lawrence Jenkins MD, performed and was present for the entire procedure from the initial incision to the closing of the skin.

Ippopwithpig

**PREOPERATIVE DIAGNOSIS:** Erectile dysfunction; Peyronie's Disease

**POSTOPERATIVE DIAGNOSIS:** Erectile dysfunction; Peyronie's Disease

**PROCEDURE:**

1. Insertion of multi-component penile implant utilizing “no-touch” technique

2. Repair penile angulation

3. Incision and grafting of penile plaque >5cm

**SURGEON:** Lawrence Jenkins, MD

**ASSISTANT:** \*\*\*

**ANESTHESIA:** General

**EBL:** 50 mL

**DRAINS:** 15Fr JP

**IMPLANT**: \*\*\*

**INDICATIONS:** The patient is a @AGE@ y.o. male with a history of refractory erectile dysfunction and severe Peyronie's Disease who elected to proceed with correction with IPP placement.

We discussed penile implant surgery given his ED. We had a discussion regarding penile implant surgery, its pros and cons and risks, and benefits including an approximately 2% infection rate and 15% re-operation rate within the first decade after primary implantation. He was counseled regarding 2-piece or a 3-piece device. He opted for the latter. The patient signed an informed consent form for the hospital and verbalized understanding of the risks, potential complications, and outcomes and requested to proceed with the operation.

**PRE-OPERATIVE PREPARATION:** The patient was seen in the weeks before surgery.  He had his pre-operative laboratory testing performed, had a urine specimen collected for culture and sensitivity.  He was instructed then to use Chlorhexidine scrub once per day while showering for the 7 days before surgery.  He was also instructed to take Bactrim DS 1 tab PO BID for the 48 hours before surgery.  On the morning of surgery, he was admitted to the pre-operative holding area having been NPO post-midnight. He had an intravenous line commenced and had the administration of Gentamicin at 5mg/kg as well as 1.5mg/kg of Vancomycin.

**OPERATION:** The patient was brought into the operating room, he had the administration of general anesthesia, and the patient was placed on the OR table with his legs in a "frog-like position" with the knees slightly bent outward and feet touching on the midline.

**SKIN PREPARATION:** The lower inguinal and penoscrotal area was shaved completely and prepped with a complete skin cleansing with two Chloraprep (Chlorhexidine/70% alcohol) applicators. The alcohol was allowed to evaporate for 3 minutes, and the patient was subsequently draped in the routine sterile fashion.

He was given bilateral pudendal blocks with 10 mL in each peri-crural space using a mixture of 0.5% ropivicaine plain – 30 mL/ dexamethasone – 4mg (1mL).

He was then draped in the standard multi-layer fashion. The penis and scrotum were then delivered through a small fenestration in the extremity drape. Throughout the procedure, copious amounts antibiotic irrigation (vancomycin/gentamicin) solution was used, and for exposure, a metal Lonestar retractor with yellow elastic stays were utilized.

**INCISION:** A circumcision incision was made and carried down to Buck's fascia.

**NO-TOUCH TECHNIQUE OF SKIN ISOLATION**:  At this point, surgical gloves, instruments, and sponges that had touched the patient's skin were removed and isolated from the surgical field. New sterile gloves were utilized to place the loose transparent surgical drape over the entire surgical field. A small opening was made in the drape exactly over the skin incision. The drape was then secured to the edges of the surgical wound with an additional four blunt yellow hooks also secured to the Scott retractor. The skin was thus completely covered, and further dissection and complete insertion of the prosthesis device could be performed through the aperture of the transparent drape without direct contact with the patient's skin.

**PLAQUE INCISION AND GRAFTING:** The neurovascular bundles was elevated with delicate dissection and the use of bipolar cautery to expose the point of maximal curvature while extending above and below this area. Once identified we used electrocautery and Mayo scissors to incise the tunica albuginea circumferentially sparing the urethra. A graft of \*\*\*TachoSil collagen fleece was used to cover the gap area and applied with pressure. This was then carried proximally to the superior portion of the scrotum. Buck's fascia was then undermined and the neurovascular bundle mobilized. The large, dorsal plaque was palpable across the majority of the distal dorsal penis. The Bovie was used to make a semicircular incision through the plaque. A tachosil graft was then placed and held down to confirm to the defect. Four blunt yellow hooks were utilized to maintain the skin incision open by being secured to the Scott retractor.

**CORPORAL DILATION AND SIZING:** The corporal bodies were incised for a length of approximately 1 inch one finger-breadth lateral to the urethral margin, between 2-0 PDS sutures on either side.  Dilation was conducted with a Dilamezinsert dilator with uneventful dilation into the crus and the glans penis for both corporal bodies. No crural perforation or urethral perforation was encountered. Each corpus cavernosum was measured independently utilizing the blunt Dilamezinsert. Both the right and left corpora were measured two times alternating sides between measurements. A total corporal length was measured at \*\*\* cm on Right and \*\*\* cm on the Left. After the corpora had been measured a second time, a decision was made to use an \*\*\* cm Coloplast \*\*\* with \*\*\* cm rear tip extenders.

**CYLINDER PLACEMENT:** At this point, the prosthesis was brought into the field and delivered from its sterile package. The prosthesis was prepared for insertion by purging all air out of the system. The device was then sized properly by adding the correct size of rear tip extenders. The cylinders were placed in the standard fashion using a Keith needle/Furlow passer system. The cylinders were lined up so that the tubing from each cylinder to the pump did not cross over each other. The cylinders were nicely seated within each corporal body.

**SURROGATE SALINE TEST:** Before closure of the corporotomy a surrogate test was performed with a filled 60 mL syringe. When fully pumped the distal tip of each cylinder reached the glans penis. The glans penis was well supported. Also, no effacement of the groove between the glans penis and penile shaft was noted and no overriding of cylinders identified. The prosthesis was appropriately sized with an excellent erection and no evidence of under or over sizing. With detumescence, minimal folding of cylinders was noted indicating that the cylinders again were appropriately sized. It took \*\*\* mL of saline to inflate the device fully.

**CLOSURE OF THE CORPOROTOMIES:** The prosthesis was deflated and the traction suture from each cylinder tip secured to the Scott retractor with mosquito clamps. The corporotomies were then closed with the 2-0 PDS preplaced sutures. Each corporotomy was then examined for hemostasis and felt to be grossly watertight.

**PENILE MODELING**: The cylinders were inflated to the maximum. Rubber-shod clamps were placed on the cylinder tubing to protect the pump. While holding the corporotomies, the penis was then bent hard in the direction opposite to the curvature for 90 seconds. After 90 seconds, the clamps were removed, and we were able to inflate the prosthesis a few more pumps due to stretching of the Peyronie’s plaque. The penile curvature was decreased and was close to 20° curvature or less.

**RESERVOIR SPACE CREATION:** The bladder was completely emptied via the Foley catheter.  Through the incision, using the index finger, a tunnel was fashioned between the inguinal cord and the base of the penis.  The left external ring was subsequently easily identified by palpation. Blunt dissection with the assistance of a finger was used to make a small opening in the floor of the right inguinal canal.  The opening was further dilated to allow the operator’s index finger.  A \*\*\* mL \*\*\* Reservoir was placed in the right pre-vesical space and filled with \*\*\* mL of normal saline. After being assured that the reservoir was without back-pressure, we turned our attention to the final part of the procedure.

**PUMP PLACEMENT:** The scrotal pump was placed in a pouch in a midline dependent position.  The pouch was fashioned with finger dissection and once the pump was placed the Dartos layer was closed with 3-0 Vicryl suture above the pump and the tubing secured deep in the wound, great care being taken not to violate the device or the tubing. Following this, the redundant tubing was excised and the reservoir and pump tubing were connected in a standard fashion with the connectors in the assembly kit. Great care was taken not to have the tubing cross over each other.

**PROSTHESIS CYCLING:** The pump was activated and deactivated several times. Each time the penis was examined and cylinder size and erection reassessed. Good cosmesis of the flaccid and erect penis was present. At this point, the device was fully inflated and deflated. Upon inflation, there was a straight rigid erection with the tips present within the glans penis. Antibiotic irrigation was used to wash out the scrotum.

**INCISION CLOSURE:** Following the achievement of complete hemostasis and final irrigation with antibiotic solution, the Buck’s fascia was closed with interrupted 3/0 Vicryl suture. The skin was closed with 4/0 Monocryl in an interrupted horizontal mattress fashion. The incisions were infiltrated with the mixture of using a mixture of 0.5% ropivicaine plain – 30 mL/ dexamethasone – 4mg. A Xeroform dressing was applied over the wound with dry sterile mummy wrap dressing over this, and a fluff gauze pads were unraveled acting as a compression dressing within a scrotal support.

The patient was awake in the operating room. He was transferred to the recovery room in stable condition.

Lawrence Jenkins MD, performed and was present for the entire procedure from the initial incision to the closing of the skin.

Ipppreopmeds

**HOW TO TAKE THE MEDICATIONS**

Please note over the counter medications (***OTC***) need to be purchased on your own and you may not get or need the assistance from a pharmacist to obtain these prescriptions.

**BEFORE THE PROCEDURE:**

**1.) Please take Bactrim DS (Trimethoprim/Sulfamethoxazole) in the morning and evening starting two days before the procedure date (with a sip of water only) ( ) , and resume the day after the procedure taking both morning and evening ( \_\_\_ ).**

**Note: Patients with Diabetes, or immune deficiencies will be prescribed an antifungal drug called Fluconazole 200mg. This is to be taken daily starting two days prior to the procedure in addition to the antibiotic. You will continue this, the morning of the procedure, and after the procedure until finished.**

**2.)** Please wash the scrotal, penile and perineal skin with Hibiclens (*OTC*) solution (PINK SOAP) two times per day for three days prior (before) to the procedure. Please rinse well after application. May irritate the skin if not rinsed thoroughly. Please DO NOT follow application directions on bottle.

**3.)** Do not shave the SCROTAL AREA prior the procedure. Dr. Jenkins will do this himself on the day of the procedure. Shaving the scrotal area prior the procedure increases bacterial colony count on the skin.

**AFTER THE PROCEDURE:**

**1.) Bactrim DS (Trimethoprim/Sulfamethoxazole)**

Antibiotic. 1 tablet to be taken at night the day after the procedure and every 12 hours thereafter for 5 days.

**Diabetes - 1b) Fluconazole 100mg (Diflucan)**

Antifungal. 2 tablets to be taken every 24 hours until finished.

**2.) Acetaminophen 500mg (Tylenol Extra Strength)**

Pain medication. To be taken starting when you get home from the procedure. 2 tablets every 8 hours.

**3.) Meloxicam 15 mg (Mobic)**

Pain medication. To be taken starting when you get home from the procedure. 1 tablet every 24 hours.

**4.) Gabapentin 300 mg (Neurontin)**

Pain medication. To be taken starting when you get home from the procedure. 1 tablets every 6 hours.

**5.) Tramadol 50mg (Ultram)**

Pain medication for breakthrough strong pain. To be taken after the procedure in case of the onset of pain beyond control with the other medications. 1 Tablet every 6 hours, only as needed.

**6.) Miralax (*OTC*) (polyethylene glycol)**

Stool laxative to be taken if the patient has not had a bowel movement after being home for 24 hours. Use as directed or take up to 3 capfuls three times per day Max.

Ippopambicor

PREOPERATIVE DIAGNOSIS: Erectile dysfunction

POSTOPERATIVE DIAGNOSIS: Erectile dysfunction

PROCEDURE: Insertion of self-contained inflatable penile prosthesis (54401) utilizing “no-touch” technique

SURGEON: Lawrence Jenkins, MD

ASSISTANT: \*\*\*

ANESTHESIA: General

EBL: 50 mL

DRAINS: None

INDICATIONS: The patient is a \*\*\*-year-old male with a history of ED who has failed conservative management.

We discussed penile implant surgery given his ED. We had a discussion regarding penile implant surgery, its pros and cons and risks, and benefits including an approximately 2% infection rate and 15% re-operation rate within the first decade after primary implantation. He was counseled regarding 2-piece or a 3-piece device. He opted for the 2-piece due to his 2 ostomies present on his lower abdomen. The patient signed an informed consent form for the hospital and verbalized understanding of the risks, potential complications, and outcomes and requested to proceed with the operation.

PRE-OPERATIVE PREPARATION: The patient was seen in the weeks before surgery. He had his pre-operative laboratory testing performed, had a urine specimen collected for culture and sensitivity. He was instructed then to use Chlorhexidine scrub once per day while showering for the 7 days before surgery. He was also instructed to take Bactrim DS 1 tab PO BID for the 48 hours before surgery. On the morning of surgery, he was admitted to the pre-operative holding area having been NPO post-midnight. He had an intravenous line commenced and had the administration of Gentamicin at 5mg/kg as well as 600mg of Linezolid.

OPERATION: The patient was brought into the operating room, he had the administration of general anesthesia, and the patient was placed on the OR table with his legs in a "frog-like position" with the knees slightly bent outward and feet touching on the midline.

SKIN PREPARATION: The lower inguinal and penoscrotal area was shaved completely and prepped with a complete skin cleansing with two Chloraprep (Chlorhexidine/70% alcohol) applicators. The alcohol was allowed to evaporate for 3 minutes, and the patient was subsequently draped in the routine sterile fashion.

He was given bilateral pudendal blocks with 10 mL in each peri-crural space using a mixture of 0.5% ropivicaine plain – 30 mL/ dexamethasone – 4mg (1mL).

He was then draped in the standard multi-layer fashion. The penis and scrotum were then delivered through a small fenestration in the extremity drape. Throughout the procedure, copious amounts antibiotic irrigation (vancomycin/gentamicin) solution was used, and for exposure, a metal Lonestar retractor with yellow elastic stays were utilized.

INCISION: A vertical midline scrotal incision was made at the penoscrotal junction approximating 5 cm in length. This was carried down to subcutaneous layers using a combination of cautery and blunt dissection until the tunica albuginea was clearly identified on both sides of the urethra. Four blunt yellow hooks were utilized to maintain the skin incision open by being secured to the Scott retractor.

NO-TOUCH TECHNIQUE OF SKIN ISOLATION: At this point, surgical gloves, instruments, and sponges that had touched the patient's skin were removed and isolated from the surgical field. New sterile gloves were utilized to place the loose transparent surgical drape over the entire surgical field. A small opening was made in the drape exactly over the skin incision. The drape was then secured to the edges of the surgical wound with an additional four blunt yellow hooks also secured to the Scott retractor. The skin was thus completely covered, and further dissection and complete insertion of the prosthesis device could be performed through the aperture of the transparent drape without direct contact with the patient's skin.

CORPORAL DILATION AND SIZING: The corporal bodies were incised for a length of approximately 1 inch one finger-breadth lateral to the urethral margin, between 2/0 Maxon sutures on either side. Dilation was conducted with a Dilamezinsert dilator with uneventful dilation into the crus and the glans penis for both corporal bodies. No crural perforation or urethral perforation was encountered. Each corpus cavernosum was measured independently utilizing the blunt Dilamezinsert. Both the right and left corpora were measured two times alternating sides between measurements. A total corporal length was measured at \*\*\* cm on the right and \*\*\* cm on the left. After the corpora had been measured a second time, a decision was made to use an \*\*\* cm (\*\*\*mm diameter) Ambicor device was chosen and \*\*\*cm rear tip extender ont he right and \*\*\* cm rear tip extender on the left.

CYLINDER PLACEMENT: At this point, the prosthesis was brought into the field and delivered from its sterile package. The prosthesis was prepared for insertion by purging all air out of the system. The device was then sized properly by adding the correct size of rear tip extenders. The cylinders were placed in the standard fashion using a Keith needle/Furlow passer system. The cylinders were lined up so that the tubing from each cylinder to the pump did not cross over each other. The cylinders were nicely seated within each corporal body.

CLOSURE OF THE CORPOROTOMIES: The prosthesis was deflated and the traction suture from each cylinder tip secured to the Scott retractor with mosquito clamps. The corporotomies were then closed with the 2/0 Maxon preplaced sutures. Each corporotomy was then examined for hemostasis and felt to be grossly watertight.

PROSTHESIS CYCLING: The pump was activated and deactivated several times. Each time the penis was examined and cylinder size and erection reassessed. Good cosmesis of the flaccid and erect penis was present. At this point, the device was fully inflated and deflated. Upon inflation, there was a straight rigid erection with the tips present within the glans penis. Antibiotic irrigation was used to wash out the scrotum.

INCISION CLOSURE: Following the achievement of complete hemostasis and final irrigation with antibiotic solution, the Buck’s fascia was closed with interrupted 3/0 Polysorb suture. The skin was closed with 4/0 Biosyn in an interrupted fashion. The incisions were infiltrated with the mixture of using a mixture of 0.5% ropivicaine plain – 30 mL/ dexamethasone – 4mg. A Xeroform dressing was applied over the wound with dry sterile mummy wrap dressing over this, and a fluff gauze pads were unraveled acting as a compression dressing within a scrotal support.

The patient was awake in the operating room. He was transferred to the recovery room in stable condition.

I, Lawrence Jenkins MD, performed and was present for the entire procedure from the initial incision to the closing of the skin.

Ipptrainingplan

- IPP training completed, he was able to inflate and deflate the device twice on his own successfully

-he will do daily cycling of the device to increase capacity

-RTC in 3 months

Lipidrec

Based on the 2013 ACC/AHA risk calculator, {HIS/HER (NO CAPS):21788} 10 year ASCVD risk is \*\*\*% and lifetime risk is \*\*\*% and so {HE/SHE (NO CAPS):19870} should \*\*\* be on a statin.

Lipidtable

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **TC** | **HDL** | **TG** | **LDL** | **Non- HDL** | **Ttl LDL-P** | **Sm LDL-P** | **Ttl HDL-P** | **Lg HDL-P** |
| *Goals:* | *<200* | *>40* | *<150* | *<100* | *<130* | *<1000* |  | *>35* |  |
|  |  |  |  |  |  |  |  |  |  |

Ljmesa

**Preoperative Diagnosis:** Bilateral absence of vas deferens

**Postoperative Diagnosis:** \*\*\*Right epididymal obstruction

**Operation:**  \*\*\*Right scrotal exploration; right microsurgical epididymal sperm aspiration; intraoperative exam, epididymal wet prep

**Surgeon:**  Lawrence Jenkins, MD

**Assistant Surgeon:** \*\*\*

**Anesthesia:** GET

**EBL**: 5 cc

**Drains/tubes:** none

**Specimens:** Right epididymal specimensto cryopreservation

none to Pathology

**Complications**: none

**Condition:** Stable

**Brief History/indications:** Mr. @Lastname@ is a @AGE@ year old year old male with secondary azoospermia.

**Procedure:**

The patient was brought to the operating room where he was placed in the supine position, shaved, and prepped and draped in the standard fashion.

A median raphe scrotal incision was fashioned, and the right hemiscrotum was entered. Because of the patient's history of abnormal examination, formal scrotal exploration was performed as a separate procedure. During scrotal exploration, the testis, epididymis, testicular blood supply, and presence of the vas deferens was confirmed, each identified and preserved.

The tunica vaginalis was noted to be intact, and it was opened widely, and the operating microscope was brought into place. Moderate adhesions within the tunica vaginalis with tunical thickening and other inflammatory changes reflected by interstitial fluid and adhesions were noted between the tunica vaginalis and tunica albuginea.

The operating scope was brought into place and the epididymis was seen to be dilated in the caput, extending to the distal caput region. Most tubules were yellow and dilated in this area, but the distal epididymis(corpus, cauda) were not dilated. The microscope was used to perform microsurgical aspiration of multiple sites along the epididymis using a micropuncture apparatus. Moderate fluid with sperm (0-1% motility) was seen in dilated tubules from the efferent ductsSamples were evaluated using a phase contrast microscope by a representative from the Andrology Lab. Intraoperative findings were consistent with distal epididymal obstruction.

The tunica vaginalis was closed with running 4-0 Polysorb, the dartos layer of muscle was closed with running 4-0 Polysorb, and interrupted horizontal mattress closure of skin was effected with 4-0 Monocryl.

Injection of 0.25% Marcaine: 1% Lidocaine was done under the tunica vaginalis, along the spermatic cord and into the scrotal sac. The subcutaneous tissues were injected using 0.25% Marcaine. The procedure was terminated with the patient in satisfactory condition and no complications.

I, Lawrence Jenkins, MD, was present throughout and performed all critical portions of the entire operation.

Microtese

NAME –@NAME@

DOB – @DOB@

MRN - @MRN@

Date of Operation– @DATE@

Pre-op Diagnosis – Testicular failure, azoospermia

Post-OP Diagnosis – same

Surgery – \*\*\* micro-surgical testicular sperm extraction, sperm identification from testis tissue, Cytopathology in OR

Asst – \*\*\*

Blood loss – \*\*\* cc

Complications – none

Anesthesia – General.

Procedure:

Mr @NAME@ was brought to the OR, properly identified by the OR staff, and placed supine on the operating room table. SCD was placed on his calves b/l. He was given general anesthesia and pre-operative antibiotics of Ancef 2 gm. Mr @NAME@ was then shaved, prepped, and draped in the usual sterile fashion with chlora-prep. Surgical time out was performed with the nursing staff and anesthesiologist present. The operating microscope was then brought into the operative filed and used for magnification for the remainder of the surgery. A 4 cm \*\*\* sided transverse scrotal incision was made using a scalpel blade. Dissection was carried down through dartos fascia using Bovie electrocautery ensuring hemostasis as dissection progressed. The tunica vaginalis was then seen and incised. The testicle was then delivered into the operative field. A 1 cm transverse incision was then made through the tunica albuginea to expose the seminiferous tubules.

The tubules were inspected under high magnification and were \*\*\*. Two biopsies were taken from opposite ends of the incision. The tissue was then processed on 2 separate glass slides. These slides were then individually assessed under a light microscope at 200x for the presence of sperm. \*\*\* sperm was seen on either slide.

A biopsy was then taken from the testicle and sent for pathology.

The transverse incision in the tunica albuginea was then expanded medially and laterally in order to bivalve the testicle. Careful attention was taken to preserve the inner vessels of the testicle. All hemostasis was achieved using bipolar cautery. A systematic approach was taken to inspect all lobules in a clock wise manner. All tubules were \*\*\*. There were a few tubules in the \*\*\* aspect of the testicle that appeared to be more full and pale. This area was specifically targeted with biospies. In total, \*\*\* additional separate biopsies were taken from superior, middle and inferior, right, mid and left areas of the testicle. Each biopsy was processed on a glass slide, and remaining tubules were placed in aliquots partially filled with human tubal fluid. Slides and aliquots were labeled separately corresponding to area of biopsy. A total of \*\*\* of \*\*\* total slides examined had sperm present. Slides demonstrated \*\*\* sperm / \*\*\* HPF \*\*\* of which demonstrated motility.

Specifically, the \*\*\* aspect of the testicle was the location that corresponded to active spermatogenesis. All biopsies were condensed into a total of \*\*\* aliquots, \*\*\* of which representing biopsies demonstrating sperm, \*\*\* of which demonstrated no sperm. These samples were later handed off to \*\*\*. It was the understanding that his \*\*\* would immediately transfer the specimen to \*\*\*. The validity of this was confirmed as I called \*\*\* following the surgery and they confirmed receipt.

At this time it was decided that in order to preserve testicular architecture, no additional biopsies would be taken. Hemostasis was then carefully achieved with bipolar cautery. The tunica albuginea was then closed with 5-0 prolene in a running, locking fashion. Tunica vaginalis was closed with running 4-0 chromic in a running, locking fashion. The dartos fascia was then closed with 3-0 vicryl sutures in a running, locking fashion. 8 cc 0.25% marcaine mix was injected in to the spermatic cord, and an additional \*\*\* cc was injected subcutaneously at the incision site. The incision was then closed with running 4-0 biosyn. The area was cleaned and dried and an incisional sealant was applied to the incision. Fluffy dressings and a scrotal support was then placed. The patient was then awoken from anesthesia and transferred to the recovery room in stable condition. He tolerated the procedure without difficulty.

Mytchartedvideosmessage

Hi Mr. @LNAME@,

Regarding erectile dysfunction. I highly recommend you check out the videos I made on erectile dysfunction at Video.LJenkinsMD.com. I also recommend videos produced by one of the device manufacturers at EDCure.org and select the "Real Stories" tab. They have some really informative patient testimonials regarding ED.

Cheers,

Lawrence Jenkins, MD, MBA

Pe

Today we discussed premature ejaculation and the treatment options. I discussed topical therapy and use of medication in an off-label fashion. I described the use of anti-depressants for this purpose. We talked about the option of taking these medications daily or on-demand 4 hours prior to sexual activity. We discussed side effects of each method. He wishes to try topical.

-Sex therapy

-sildenafil to improve erection quality and endurance

Pedt

Premature Ejaculation Diagnostic Tool

How difficult is it for you to delay ejaculation?

0 - Not difficult at all

1 - Somewhat difficult

2 - Moderately difficult

3 - Very difficult

4 - Extremely difficult

Do you ejaculate before you wish?

0 - Almost never or never

1 - Less than half the time

2 - About half the time

3 - More than half the time

4 - Almost always or always

Do you ejaculate with very little stimulation?

0 - Almost never or never

1 - Less than half the time

2 - About half the time

3 - More than half the time

4 - Almost always or always

Do you feel frustrated because of ejaculating before you want to?

0 - Not at all

1 - Slightly

2 - Moderately

3 - Very

4 - Extremely

How concerned are you that your time to ejaculation leaves your partner sexually unfulfilled?

0 - Not at all

1 - Slightly

2 - Moderately

3 - Very

4 – Extremely

Penilerehab

Today we had a long discussion regarding the rehabilitation process for erections post-operatively. We discussed the role of nerve sparing during the surgery. I described the typical pathway of PDE5 inhibitor. I explained the rationale that this is proven to maintain penile length and allow early sexual activity. We discussed the cost of each. I also discussed other options including penile injections. We talked about the cost of injections and that this often helps patients return to sexual activity earlier. Discussed the option of not doing any rehabilitation and likely course of prolonged erectile dysfunction. During this we talked about the risk of permanent erectile dysfunction but that we can begin treatment at his discretion. He wishes to consider \*\*\*

**Peyroniesbrieftalk**

We had a discussion today regarding Peyronie's disease and the two phases, acute and chronic. I believe he is currently in the **\*\*\*** phase. We discussed causes of penile curvature and the potential medical treatments. We discussed intralesional collagenase or verapamil injections, as well as surgical treatments including penile prosthesis, corporal plication or plaque incision and grafting. We will plan to have the patient be scheduled for a **Deformity Assessment and Penile Doppler Duplex ultrasound** in the office.

Peyroniesdetailedoptions

We discussed all the treatment options for Peyronie's Disease at length.

These include the following:

1. Observation. We discussed the likelihood of progression. Given that his curvature has stabilized, I would quote him a relatively low risk of progression. Overall, it is thought that a 10-12% of patients get better, a 60% stay the same and a 20-25% get worse. My experience is fewer get better and more get worse or stay the same.

We discussed that there are no oral therapies for Peyronie disease. The next option is a penile traction device. This is a mechanical traction device with limited data to support its use. However, the general concept of mechanical forces being able to help remodel structural abnormalities is not inconceivable. This would be considered off-label and without any strong evidence to support it.

2. The next option would be verapamil, delivered intralesionally. Intralesional verapamil has some moderate level of evidence is supported. A minimum of 6-injection treatments, separated by 2 weeks each, over a 3-month period is associated with a reduction in curvature and pain. In our experience, we have seen more stabilization, pain reduction and fewer improvements. Intralesional verapamil hasa very limited side effect profile with the possibility of bruising the therapy.

3. The next option would be Xiaflex (collagenase), delivered intralesionally. Intralesional collagenase has recently been FDA approved for the treatment of stable, dorsal and/or lateral curvatures. The average improvement was 17 degrees (34%). The treatments include 4 cycles of 2 injections separated by approx 1 week followed by a six week break. This is combined with penile traction therapy which is begun 1 week after the second treatment. Total therapy takes about 24 weeks.

4. Final option would be surgical interventions.

-For moderate curvature, without significant hourglass narrowing, and good erectile function, penile plication offers a simple, safe approach. The principle involves placing sutures in the side opposite the curvature. These plication sutures in the tunica albuginea slightly shorten the tunica albuginea to normal or long side of the penis. The chance of correcting the curvature to within 5 degrees of normal is over 95%. The risks are relatively limited including a small risk of infection, bruising and numbness. The risk of erectile dysfunction is limited. It is an outpatient procedure, it takes 1 hour to perform, and has a limited pain and time away from work.

-The alternative approach is incision of the plaque and grafting. This is a more extensive procedure which involves mobilization of the neurovascular bundle dorsally, or corpus spongiosum ventrally, an incision through the tunica albuginea at the point of scarring, and placement of a graft in to substitute for the tunica albuginea. This operation takes approximately 2-3 hours to complete and has a considerably longer penile rehabilitation period. It may take up to 8-9 months to fully regain sexual function. There are also significant risks of erectile dysfunction with this approach. There is also risk of numbness when we are mobilizing the dorsal neurovascular bundle. In my experience, these have all resolved, but it takes 3 to 6 months for resolution to occur. Ninety-five percent of patients have a straight penis, but in the few residual patients with persistent curvature, plications may be effective.

When the condition is stabilized and there is no new curvature for 3-6 months, then xiaflex or surgery is appropriate. Patients with severe curvature, very significant shortening, or profound hourglass narrowing need grafting procedures. All other patients are potentially candidates for penile plication with its lower risk profile.

A penile implant may be an option for those patients with bad erectile dysfunction and penile deformity. Often times the rigidity of the implant resolves most of the curvature.

Plicationdorsalcpc

PREOPERATIVE DIAGNOSIS: Congenital penile deviation.

POSTOPERATIVE DIAGNOSIS: Congenital penile deviation.

NATURE OF OPERATION: Penile plication.

ESTIMATED BLOOD LOSS: 50 mL.

INDICATION: The patient is a male with congenital ventral curvature associated with Peyronie’s disease. The patient underwent preoperative Duplex Doppler ultrasonography of the penis and had excellent erectile hemodynamics and he about a 45-degree curvature. The patient was counseled regarding the pros and cons and risks and benefits of plication surgery and he requested to proceed.

PREOPERATIVE PREPARATION: The patient brought into clinic 1 week prior to surgery. He had his preoperative laboratory testing performed and had his consents conducted as well as his preadmission test.

OPERATIVE PROCEDURE: The patient was brought into the operating room, was laid supine upon the table, had the administration of general anesthesia by LMA. The genitalia were shaved. He was scrubbed with Betadine solution and painted with Betadine and draped in a standard multilayer fashion.

INCISION: A circumcising incision was made externally along the coronal sulcus, care being taken not to advance the pre-pubic or scrotal skin. An internal incision was made 5mm from the coronal sulcus. It was carried down to Buck’s fascia. The redundant skin was excised and sent ot pathology. The proximal shaft skin was degloved to the base of the penis. Hemostasis was achieved with a combination of monopolar and bipolar cautery.

DEEP DORSAL VEIN EXCISION: Under loupe magnification using Jerrold forceps and tenotomy scissors, Buck’s fascia was opened, segments of the deep dorsal vein were resected. Multiple emissary veins were addressed with bipolar cautery. Great care was taken to avoid damage to the dorsal arteries which were identified using a Doppler ultrasound probe. Numerous neural channels were identified lateral to the dorsal arteries, but none across the midline.

PLICATION: Once a clear segment of tunica albuginea was identified in the midline, an artificial erection was induced through a 19-gauge butterfly needle placed through the right corporal body via the glans. Then, 30 units of papaverine (30 mg/mL) was instilled and then injectable saline was injected through the butterfly needle to generate a full erection. At two points along the shaft, 8-point #0 Ticron suture was used to plicate with almost complete resolution of the ventral curvature upon repeat artificial erection – at junction of the mid-distal 1/3s and the proximal shaft – approximately 5 cm apart. A repeated artificial erection was achieved with saline alone and almost complete correction of the curvature was seen (5 degrees).

CLOSURE: Hemostasis was achieved with bipolar cautery. The skin was replaced into its anatomical position. 4-0 Monocryl suture was used in an interrupted horizontal mattress fashion to evert the skin edges at the 12, 3, 6, and 9 o'clock positions. Between these, 4-0 Monocryl suture was used to re-appose the skin edges in a simple interrupted fashion. A Xeroform dressing was placed over this and 4 x 4 gauze over this and a lightly wrapped Coban dressing was placed over the penis. 0.5% plain bupivacaine block was instilled at the base of the penis to anesthetize these dorsal nerves. The patient was extubated in the operating room and was transferred to the recovery room in stable condition.

I was present for the entire procedure.

Plicationpd

PREOPERATIVE DIAGNOSIS: Dorsal curvature secondary to Peyronie’s disease

POSTOPERATIVE DIAGNOSIS: Dorsal curvature secondary to Peyronie’s disease.

NATURE OF OPERATION: Ventral penile plication.

ESTIMATED BLOOD LOSS: 25 mL.

INDICATION: The patient is a male with Dorsal penile curvature associated with Peyronie’s disease. The patient underwent preoperative Duplex Doppler ultrasonography of the penis and had excellent erectile hemodynamics. The patient was counseled regarding the pros and cons and risks and benefits of plication surgery and he requested to proceed.

OPERATIVE PROCEDURE: The patient was brought into the operating room, was laid supine upon the table, had the administration of general anesthesia. The genitalia were shaved. He was scrubbed with chloraprep sticks and draped in a standard fashion. 0.5% plain bupivacaine block was instilled at the base of the penis to anesthetize these dorsal nerves.

INCISION: A ventral raphe\*\*\* incision was made. Hemostasis was achieved with a combination of monopolar and bipolar cautery.

PLICATION: An artificial erection was accomplished using intrcavernosal papaverine and saline and the curvature was mapped out. The 21-gauge butterfly needle was placed through the right corporal body via the glans. At two points along the shaft, 8-point #0 Ticron suture was used to plicate with almost complete resolution of the ventral curvature upon repeat artificial erection – at junction of the mid-distal 1/3s and the proximal shaft – approximately 5 cm apart. A repeated artificial erection was achieved with saline alone and almost complete correction of the curvature was seen (5 degrees).

CLOSURE: Hemostasis was achieved with bipolar cautery. The skin was replaced into its anatomical position. 4-0 Biosyn suture was used in subcuticular fashion. A Xeroform dressing was placed over this and 4 x 4 gauze over this and a lightly wrapped Coban dressing was placed over the penis. The patient was extubated in the operating room and was transferred to the recovery room in stable condition.

Lawrence Jenkins, MD, MBA, was present for the entire procedure.

Plicationventralcpd

PREOPERATIVE DIAGNOSIS: Congenital dorsal penile deviation.

POSTOPERATIVE DIAGNOSIS: Congenital dorsal penile deviation.

NATURE OF OPERATION: Penile plication surgery.

ESTIMATED BLOOD LOSS: 20 mL.

DRAINS: Subcutaneous penile drain.

**INDICATIONS**: The patient is an 18-year-old Caucasian male with congenital dorsal penile curvature such that the penis during erection was fixed to his anterior abdominal wall with resultant diffuclty with pentrativ sexual relations. There was no suspoensory ligament problem as under anesthesia his erect penis could be distracted from the anterior abdominal wall. We had a lengthy discussion regarding penile plication surgery. He understood the risks, potential complications, and outcomes, and he requested to proceed.

**PRE-OPERATIVE PREPARATION:** The patient was seen one week prior to surgery. He had his pre-operative laboratory testing performed at that time. On the morning of surgery he was admitted to the pre-operative holding area having been NPO post midnight. He had an intravenous line commenced and had 1 g of cefazolin administered.

**OPERATIVE PROCEDURE**: He had his genitalia shaved. He was scrubbed and painted with Betadine and he was draped in the standard fashion. Prior to any incision, an artificial erection was induced following 50 units of papaverine (30 mg/mL) followed by instillation of injectable sterile saline, through a 21-gauge butterfly needle through the right side of the glans. He had a curvature identified and a decision was made to perform a ventral, median raphe incision on the penile shaft to extend into the upper scortum. An incision was made approximating 2 inches in length.

**PLICATION**: Using a Jerrolds forceps and fine tenotomy scissors, the adventitial layer overlying the corpus spongiosum was elevated and the tunica albuginea for approximately 1 cm lateral to the urethral margin on both the right and left corporal bodies was clearly identified. Hemostasis was achieved with a combination of monopolar and bipolar cautery. A Metal Lone Star retractor and blue elastic stays were utilized for exposure. The point of maximum curvature was chosen for the site of placement of the sutures. An 8-dot technique was used on both the right and left side, very close to the urethral margin.

A 0 Ticron suture was used bilaterally to imbricate the tunica albuginea, and this was cinched down and a new artificial erection was induced. There was excellent improvement with almost compolete resolution of the curvature and the penis now hung during maximum erection at 45 degrees from the body.

**CLOSURE**: Following the achievement of complete hemostasis, the adventitial layer was approximated over the urethra with running 3-0 Vicryl suture. Skin edges were reapposed in the subcuticular fashion with 5-0 Monocryl suture. Steri-Strips and Mastisol were applied over this. A mummy wrap was applied to the scrotum with fluffed gauzes outsdie of this. Exparel local anesthetic block for a total of 5 mL was instilled into the incision. A scrotal support was applied over this. The patient was extubated in the operating room and was transferred to the recovery room in stable condition.

I, Lawrence Jenkins, MD, MBA, was present for the entire procedure.

Postgreenlight

**PVP Post-Operative Instruction**

**What to expect after discharge from the hospital**

1. You may have red tinge color (minor bleeding) in your urine for several weeks after your procedure. Do not worry if it is intermittent and light.
2. Your may have increased frequency, urgency and /or urge incontinence (leaking urine) after the procedure. This is acceptable as the bladder is re-adjusting after the surgery.
3. You may have penile pain/discomfort after the procedure for a few days to a week.

# **What medications you will be taking after surgery**

1. You will be given antibiotics for 7-10days after surgery
2. If you have been taking Uroxatral or Flomax you may stop.
3. If you have been taking Avodart or Proscar continue

# **When you should call our office**

1. If you have a fever
2. You have severe burning with urination
3. Heavy bleeding
4. You are unable to urinate

# **When you should follow up in the office**

You should make an appointment with our office 7-10 days after surgery. Please come to the office with a full bladder.

**Post-Operative Instructions** **for TURP / Laser Prostatectomy/TUMT/TUNA**

**Activity**

1. No heavy lifting (more than 15 lbs.) for 4 weeks.
2. No driving for 2 weeks.
3. No long trips for 3 weeks.
4. No cutting the lawn, shoveling snow, raking leaves, etc., for 4 weeks.
5. No sexual activity for 6 weeks after surgery.
6. Showers okay.
7. Regular light activity is encouraged several times daily. We encourage walking. Do not be a couch potato.
8. If discomfort returns then reduce activity, take it easy, and more gradually resume activities.

**Diet**

1. Drink plenty of fluids. We recommend 24-32 oz over your usual daily fluid intake. Limit fluids after 6 PM. Avoid tea, coffee (including decaf) and soda.
2. Resume a regular diet at home. Take high calorie supplements if your appetite is poor.
3. If you have a special diet secondary to Diabetes, Renal Disease, Liver Disease, etc. you may resume eating when tolerated.

**Medication**

1. Please take the medications as prescribed by your doctor. Start them on day of discharge, and please complete the entire prescription. Take pain medication only as needed. Try Tylenol or Motrin for milder pain. You will typically be discharged with your old medications and antibiotics.
2. Resume all medications you normally took before surgery, unless instructed otherwise. Do not take blood thinners or aspirin products for 1-2 weeks or as directed.
3. If there is a problem taking or getting the medication, call us.

**Catheter Care**

1. If you have a catheter in place, wash around it gently with soap and water. Keep the catheter taped to your thigh or abdomen to avoid inadvertent jerking or pulling. Do not disconnect the catheter from the drainage bag unless directed by your doctor. You may apply Bacitracin ointment at the point the catheter enters your body.

**Bowel Movements**

1. Do not strain when having a bowel movement. Expect irregular bowel habits after surgery until fully recovered. Increase fiber in your diet.
2. You may need to use a stool softener or laxative. Try Colace (Docusate Sodium), Metamucil or Milk of Magnesia at your local pharmacy.

**When to Contact your Doctor**

1. Excessive bleeding or passage of large clots. Also if you feel your bladder is not draining or if you are unable to urinate.
2. Fevers greater than 101º F, excessive chills.
3. Nausea and vomiting or inability to keep down fluids.
4. If you have any questions or concerns that are not covered by this handout.
5. Significant tenderness or swelling in the legs, chest pain, shortness of breath.
6. If it is a serious emergency, go to the Emergency Room or call 911.
7. Please call the office to arrange your 1 week follow-up appointment.

postmesa

Microsurgical Epididymal Sperm Aspiration – Post-Operative Care

1. **It is likely that you will have some discomfort for the first two to three weeks after surgery.** At the time of discharge from the hospital, you will have been given a prescription for pain medication. When taking pain medication, be careful as you walk or climb stairs. Dizziness is not unusual.
2. **Swelling and bruising of the penis and scrotum are normal and will take about three weeks to completely resolve.**
3. **Applying ice to the incision for 48 hours post-operatively will help decrease pain and swelling.**
4. A small amount of bright red blood showing through the gauze dressing is to be expected. **Do not be alarmed.** If you feel that the amount is excessive, call my office. You may replace bloody bandages with clean ones. If there isn’t any bleeding, the wound need not be covered with gauze.
5. Do not make any important judgment decisions for 24 hours after anesthesia.
6. A low-grade fever (to 101o) is common 2 – 3 days post-operatively. This fever can be lessened by coughing, deep breathing and walking. There is no danger that these activities will disrupt your incisions. Taking pain medication one hour before activities and placing a pillow over your lower abdomen when coughing will help decrease discomfort.
7. **You should shower 24 hours after surgery.** Before showering, remove the scrotal supporter and gauze dressings. **Do not remove the glue directly on the incision.** Discard the dirty dressings. Allow the warm water to run over the incisions and wash gently with soap. Pat dry.
8. You should shower every day until you return to see Dr. Jenkins. Do not take tub baths for at least one week after surgery.
9. It is not necessary to wear the scrotal supporter after 72 hours.
10. There are no stitches to be removed. The stitching is beneath the skin and dissolves.
11. You will feel a hard ridge as if a pencil is buried under the skin where the incision is. This is from the muscles sewn up under the skin and is normal. It will gradually soften and flatten out over the next few weeks.
12. **Do not return to work for 2-3 days post-operatively**.
13. **Do not drive for the first 24 hours after the surgery,** but you can ride in a car if someone else is driving.
14. **No heavy work, strenuous exercise or sports are allowed for 1 weeks post-operatively.**
15. No sexual intercourse is allowed for one week post-operatively.
16. Thereafter, you may resume normal activities as you feel up to it.
17. Remember that your pain medication may cause constipation. To avoid straining, increase your fiber intake (fruits, vegetables, whole grains, figs, etc.) and drink lots of water. If necessary, you can take 2 tablespoons of Milk of Magnesia at bedtime. You may also take Colace (stool softener) while you are taking the pain medication.

**Follow-up visits:** You should make an appointment to see Dr. Jenkins for a post-surgical visit one month after surgery.

## **If you have any questions, please feel free to call our office.**

1. For questions during office hours (Mon-Fri 9am-4:30pm) call **614-293-8155**.
2. For any emergency questions on weekends/outside of office hours, call **614-293-8000** and ask to speak to the resident on-call**.**

Postvassarnms

The American Urological Association Vasectomy Guidelines state that patients may stop using other methods of contraception when examination of one well-mixed, uncentrifuged, fresh post-vasectomy semen specimen shows azoospermia or only rare non-motile sperm (RNMS or = 100,000 non-motile sperm/mL). Based on your sample, you meet this criteria and can stop using contraception. There is always that 1 in 2000 - 4000 risk of pregnancy.

Lawrence C Jenkins, MD

Postvassaclear

The American Urological Association Vasectomy Guidelines state that patients may stop using other methods of contraception when examination of one well-mixed, uncentrifuged, fresh post-vasectomy semen specimen shows azoospermia or only rare non-motile sperm (RNMS or = 100,000 non-motile sperm/mL). Based on your sample, you meet this criteria and can stop using contraception. There is always that 1 in 2000 - 4000 risk of pregnancy.

Lawrence C Jenkins, MD

PVSA too high

Sperm count too high. Must repeat in 4 weeks. Needs Order

Dischargevxsurg

Microsurgical Varicocelectomy – Post-Operative Care

1. **It is likely that you will have some discomfort for the first two to three weeks after surgery.** At the time of discharge from the hospital, you will have been given a prescription for pain medication. When taking pain medication, be careful as you walk or climb stairs. Dizziness is not unusual.
2. **Swelling and bruising of the penis and scrotum are normal and will take about three weeks to completely resolve.**
3. **Applying ice to the incision for 48 hours post-operatively will help decrease pain and swelling.**
4. A small amount of bright red blood showing through the gauze dressing is to be expected. **Do not be alarmed.** If you feel that the amount is excessive, call my office. You may replace bloody bandages with clean ones. If there isn’t any bleeding, the wound need not be covered with gauze.
5. Do not make any important judgment decisions for 24 hours after anesthesia.
6. A low-grade fever (to 101o) is common 2 – 3 days post-operatively. This fever can be lessened by coughing, deep breathing and walking. There is no danger that these activities will disrupt your incisions. Taking pain medication one hour before activities and placing a pillow over your lower abdomen when coughing will help decrease discomfort.
7. **You should shower 24 hours after surgery.** Before showering, remove the scrotal supporter and gauze dressings. **Do not remove the glue directly on the incision.** Discard the dirty dressings. Allow the warm water to run over the incisions and wash gently with soap. Pat dry.
8. You should shower every day until you return to see Dr. Jenkins. Do not take tub baths for at least one week after surgery.
9. It is not necessary to wear the scrotal supporter after 72 hours.
10. There are no stitches to be removed. The stitching is beneath the skin and dissolves.
11. You will feel a hard ridge as if a pencil is buried under the skin where the incision is. This is from the muscles sewn up under the skin and is normal. It will gradually soften and flatten out over the next few weeks.
12. After surgery you may feel a “hardness” or tube-like structure above the testes. This is caused by thrombosis (clotting off of) the blood vessel of the varicoceles. This will dissolve in 6 – 12 weeks.
13. Enlarged, hard veins on the penis are normal following your surgical procedure. They will resolve in 2 – 3 weeks.
14. **Do not return to work for one week post-operatively**. If, however, your job involves only desk work and light activity, you may return 3 or 4 days after the surgery.
15. **Do not drive for the first week after the surgery,** but you can ride in a car if someone else is driving.
16. **No heavy work, strenuous exercise or sports are allowed for 3 weeks post-operatively.**
17. No sexual intercourse is allowed for one week post-operatively.
18. Thereafter, you may resume normal activities as you feel up to it.
19. Remember that your pain medication may cause constipation. To avoid straining, increase your fiber intake (fruits, vegetables, whole grains, figs, etc.) and drink lots of water. If necessary, you can take 2 tablespoons of Milk of Magnesia at bedtime. You may also take Colace (stool softener) while you are taking the pain medication.
20. **Follow-up visits:** You should make an appointment to see Dr. Jenkins for a post-varicocelectomy visit one month after surgery. You should also make an appointment for a semen analysis 3 months after surgery. Another semen analysis will be done 6 months after surgery and then every 6 months until your wife becomes pregnant.

**If you have any questions, please feel free to call our office.**

Prskinbridge

DATE PERFORMED: {Date; EDD:63023337}

PREOPERATIVE DIAGNOSIS: Penis skin bridge

POSTOPERATIVE DIAGNOSIS: Penis skin bridge

PROCEDURE: Lysis of penile skin bridge

SURGEON: Lawrence C Jenkins, MD

ASSISTANT: \*\*\*

ANESTHESIA: local

BLOOD LOSS: none.

INDICATIONS FOR PROCEDURE: @NAME@ is a @AGE@ circumcised male who presented with penile skin bridge that would like to have removed. The risks of the procedure were discussed including postoperative pain, infection, bleeding. He elected to proceed. Informed consent was obtained.

DESCRIPTION OF PROCEDURE: The skin of the penis was prepped with chloroprep. 1.5 mL of a 0.25% marcaine was injected in the penile shaft skin. The skin bridge was located on the \*\*\* glans. A hemostat was used to crush the skin bridge, after which it was divided with the battery powered Bovie. There was no bleeding. He tolerated this well. Bacitracin was applied to the skin edges and the penis was wrapped with sterile dressing.

I, Lawrence Jenkins, MD, was present for the entire procedure.

PTNS

I feel PTNS (Percutaneous Tibial Nerve stimulation) using the Urgent-PC neuromodulation device by Uroplasty would be a good treatment option for the patient as it is an office procedure, low cost, safe and effective treatment for UUI. Urgent PC patient response ranges from 60%-80%. Patient would receive a 30 minute in-office treatment weekly for 12 weeks then Q 3-4 week maintenance therapy.

Ptnsfu

**HPI**

@AGE@ patient presents for @HIS@ #**\*\*\*** PTNS treatment.

We are treating refractory OAB and pt has frequency and urgency

{He/she (caps):30048} has \*\*\* noticed improvement in symptoms.

**Review of Systems**

Constitutional: No fevers or chills

Gastrointestinal: Negative for constipation, nausea or vomiting

Genitourinary: Negative for gross hematuria or dysuria

Musculoskeletal: Negative for flank pain

**Physical Exam**

@VS@

Constitutional: NAD, WDWN.

Abdominal: Soft. No distension, tenderness, masses or guarding. No CVA tenderness.

Extremities: MOE x 4, Warm. No clubbing. No cyanosis.

Skin: Pink, warm and dry. No rashes noted.

**Percutaneous Tibial Nerve Stimulation Log** **@ED@:**

@FLOW(6582)@

@FLOW(6588)@

This procedure was done under my direct supervision. I was in the immediate area for the entire portion of the procedure.

**Plan**

We will plan@HIS@ treatment #\*\*\* next week.

PVS

Preoperative Diagnosis: Anejaculation due to spinal cord injury

Postoperative Diagnosis: Anejaculation due to spinal cord injury

Procedure/Operation Performed: Penile vibratory stimulation

Attending Surgeon: @ME@

Resident Surgeon: \*\*\*

Anesthesia: None

Preparation: None

EBL: None

Complications: None

Indications for Procedure: This @AGE@ @SEX@ presents with anejaculation due to spinal cord injury.

Procedure and Findings: Sublingual nifedipine {AMB URO WAS, WAS NOT:2100320006}. Vibration parameters were amplitude of {AMB NUMBERS 1.0- 4.0:2100320008} mm at 100Hz. Ejaculation {WAS/WAS NOT:2100118327} induced. A total of \*\*\* antegrade ejaculation[s] {was/were:28755} \*\*\*. Peak blood pressure was \*\*\*.

Impression: Uneventful PVS procedure

A time-out was completed verifying correct patient, procedure, site, positioning, and implant(s) or special equipment.

Rosnormal

**Review of Systems**

Constitutional: Negative for fever, chills, weight loss and malaise/fatigue.

Skin: Negative for rash, itching and skin lesions.

HENT: Negative for sore throat and sinus pain. There is no ear discharge.

Eyes: Negative for blurred vision, double vision and eye pain.

Cardiovascular: Negative for chest pain, palpitations and leg swelling.

Respiratory: Negative for cough. Is not experiencing shortness of breath or wheezing.

Gastrointestinal: Negative for heartburn, nausea, vomiting and abdominal pain.

Genitourinary: Negative for bladder incontinence, dysuria and frequency.

Musculoskeletal: Negative for back pain, joint pain and neck pain.

Neurological: Negative for dizziness, tremors and headaches.

Psychiatric: Negative for depression and suicidal ideas. The patient is not nervous/anxious.

Allergy/Immunology: Negative for environmental allergies and urticaria.

Lymph/Heme: Negative for bruises/bleeds easily and lymph node swelling.

Endocrine: Negative for polydipsia and hot flashes.

Semenchart

**Semen Analysis**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date | Volume | Conc | Motility | Fwd prog | Activity | Normal Morph | Absti | Post Wash TMC | comment |
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Sildenafil

ED - sildenafil 100 mg. Take on an empty stomach (1 hour after a meal) and 1 hr before erection desired. Or take 2 hours before dinner if planning on an evening erection and the medication is in your system for 8-10 hours. This is a boost to your natural function and requires both physical and mental stimulation.

Spermaticcordblock

The patient was consented for the procedure after risks/benefits were discussed.  
Left\*\*\* spermatic cord was identified and grasped between my thumb and forefinger. The site overlying this was prepped. At this time, a 25-gauge sterile hypodermic needle was introduced. This was advanced until the needle was felt to be within the substance of the spermatic cord. Aspiration at this site was negative. We then introduced 10 mL of 0.5% bupivicaine plain. \*\*\*This was then repeated on the right side without any complication.

He will call back tomorrow to report his results.

Lawrence C Jenkins, MD

Spermatocelectomy

PREOPERATIVE DIAGNOSIS: {left/right:311354} spermatocele.

POSTOPERATIVE DIAGNOSIS: {left/right:311354} spermatocele.

PROCEDURE: right spermatocelectomy

SURGEON: Lawrence C Jenkins, MD

ASSISTANT: \*\*\*

ANESTHESIA: LMA.

ESTIMATED BLOOD LOSS: \*\*\* mL.

COMPLICATIONS: none

DRAINS: None.

SPECIMENS: epididymal lesion

INDICATIONS: @NAME@ is a @AGE@ y.o. gentleman who has noted the spermatocele. This does fluctuate in size and rarely causes discomfort. He {HAS HAS NOT:19958} had an ultrasound that was consistent with an epididymal cyst. He came to the office desiring definitive treatment for this. We did discuss that it is likely to not cause any problems in the future; however, surgical correction was available and the risks associated with that. He wished to proceed. He {Does/does not:20985} want future children and a partial epididymectomy was an option if necessary. Informed consent was obtained.

DESCRIPTION OF PROCEDURE: @NAME@ was properly identified and brought to the procedure room. He was laid supine on the table, and sequential compression devices were placed. He was given perioperative antibiotics and underwent the smooth induction of anesthesia. An \*\*\* was placed, and then the patient's scrotum was shaved, followed by prepping with \*\*\*. He was then draped in standard sterile fashion. A timeout was performed and the procedure begun.

A \*\*\*-cm midline scrotal raphe incision was created through the skin with a 15-blade scalpel and carried down through the dartos muscle with electrocautery. This was carried all the way down onto the {left/right:311354} testicle, which was able to be delivered once entering the tunica vaginalis. Once this was accomplished the tunica vaginalis was rolled back similar to the correction of a hydrocele and the epididymis exposed. It was noted that there was approximately a \*\*\*-cm cystic lesion coming off the epididymal \*\*\*. This was dissected gently free with sharp-tipped hemostat and electrocautery. We were able to dissect this down to a small stalk. The small stalk was ligated with a \*\*\* suture and the sac completely excised and sent off the table for pathologic evaluation. \*\*\*At this point we ensured that there was excellent hemostasis both in the scrotal tissue as well as along the testicle. A 3-0 chromic suture was utilized to whip-stitch the tunica vaginalis edges. Care was taken not to cause compression along the spermatic cord. A spermatic cord block with bupivacaine {WAS:18477} performed and again hemostasis ensured. Once this was complete the testicle was placed in its proper anatomic position back into the scrotum, ensuring that the vas was posterior. The dartos muscle was then closed with a 3-0 chromic suture followed by a 4-0 chromic suture running of the skin. The skin {WAS:18477} then injected with bupivacaine as well.

The patient tolerated the procedure well and was subsequently awoken without difficulty. He was taken to the recovery unit and allowed to wake up. At the end of the procedure all instrument, needle, and sponge counts were correct. I was present in the room for the entire procedure.

PLAN: We will plan to have the patient return in approximately 4 weeks for a wound check. I did describe the use of ice over the next 48 hours

to minimize swelling.

Stentpull

Preoperative diagnosis: Nephrolithiasis\*\*\*

Postoperative diagnosis: Nephrolithiasis

Procedure: Flexible Cystourethroscopy with stent removal.

Attending surgeon: Lawrence Jenkins, MD, MBA

Anesthesia: 2% lidocaine jelly intraurethrally.

Complications: none.

**Indications**: @AGE@ @SEX@ who is status post {Right/left:16020} ureteroscopy with holmium laser lithotripsy on \*\*\* who presents for stent removal.

**Procedure**: Detailed information of all possible complications and side effects were discussed with the patient. Informed consent was obtained. Patient was given one dose of antibiotics. The patient was placed in supine position. Then the patient was prepped and draped in standard sterile regular fashion. 2% lidocaine jelly was injected into the urethra without any difficulty. The flexible cystoscope was introduced into the meatus, and up into the bladder. The stent was visualized, grasp, and removed. This was confirmed to be completely intact. The patient tolerated the procedure well. I was present in the room for the entire procedure.

**Diagnostic Testing**:

KUB today: \*\*\*

**Plan**:

1. Provided education regarding water intake of at least 2.5 liters per day

2. F/u in 3 months with a renal u/s.

Lawrence C Jenkins, MD, MBA was in the procedure room for the entire duration of the procedure.

Surgrisks

I had a long discussion with this patient about \*\*\*. Like any other surgical procedure, injury to surrounding organs is possible during the surgery. Known surrounding organ injuries include the \*\*\*. Cardiovascular risks such as an MI or PE are not uncommon to any surgical procedure requiring general or regional anesthesia. All questions were answered and patient wants to proceed in this manner.

Syringesandneedles

Needles and syringes are available on Amazon Prime.

<https://www.amazon.com/dp/B00UY5DC0G/ref=sxbs_sxwds-stvpv2_2?pf_rd_m=ATVPDKIKX0DER&pf_rd_p=3524794302&pd_rd_wg=tLxNM&pf_rd_r=8ERJGJQW6Q8XQNCBGAFY&pf_rd_s=desktop-sx-bottom-slot&pf_rd_t=301&pd_rd_i=B00UY5DC0G&pd_rd_w=vIgy6&pf_rd_i=18+ga+blunt+needle&pd_rd_r=80b18005-4b72-4022-ab5b-59024060d6c0&ie=UTF8&qid=1522346284&sr=2>

<https://www.amazon.com/Terumo-25-0-50x16-Thin-Wall/dp/B0768W3YD1/ref=sr_1_fkmr0_2?s=industrial&ie=UTF8&qid=1521200555&sr=1-2-fkmr0&keywords=25+ga+needles+terumo>

<https://www.amazon.com/dp/B071GZP1QP/ref=sspa_dk_detail_2?psc=1&pd_rd_i=B071GZP1QP&pd_rd_wg=V2SMp&pd_rd_r=Q3CFKHZZEMN5DTRH4QPQ&pd_rd_w=auyHZ>

TCDose

**Testosterone Cypionate 50 mg (0.25 mL) off-label subcutaneously Sun/Thur**

**Labs in 3-4 wks (Total and Free Testosterone, Estradiol, LH, H/H)**

Tchart

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date/Time | Total T | Free T | SHBG | LH | FSH | E2 | Hct | Pro | TSH | HbA1c | PSA |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |

Tconvo

He would like to have us manage his testosterone therapy. We will obtain new labs. We discussed the various risks/benefits of treatment. He was given Testosterone Therapy: What you should know from the AUA Foundation, the SMSNA position statement on Testosterone and Cardiovascular Risk. He was given the opportunity to ask questions. We discussed that there are no long-term safety data for testosterone therapy and cardiovascular disease and/or prostate cancer. We discussed the various treatment options including gels, injections (off-label twice weekly subcut injection and also long-term), pellets, pills and off-label clomiphene.

-Pending labs we will start **\*\*\*** and reassess labs in 3-4 weeks.

-Labs : TT, FT, E2, LH, H/H

TESA

**PREPAID ELECTIVE SURGERY**

Procedure: spermatic cord nerve block bilateral, testis aspiration, epididymal aspiration, cytologic examination of the specimen

Anesthesia: Bupivicaine

Estimated Blood Loss: minimal

Specimen: to IVF lab

Indications: obstructive azoopsermia

PROCEDURE: After identifying the correct patient, he is brought into the procedure room, placed in the supine position, and prepped and draped in the usual sterile fashion. The right testis is brought to the anterior scrotal skin, taking care to keep all associated structures posterior. After local anesthesia is injected in both the spermatic cord and the skin overlying the testis, a 21 G butterfly needle attached to a 10cc syringe is used to aspirate testicular tissue. Multiple passes are made, with the aspirated tissue and fluid passed off to the Reproductive Testing Lab personnel for confirmation of sperm. Due to low numbers we did the same procedure on the left side, along with aspiration of bilateral epididymides to improve acquisition. When adequate tissue is obtained, pressure is held over the testis to ensure hemostasis. Estimated blood loss was immeasurable. Sterile dressing, fluffs, and athletic supporter are then applied, and the patient is taken back to the clinic for monitoring in stable condition. Mature motile sperm are noted.

IMPORTANT REIMBURSEMENT NOTE REGARDING THE CPT CODE (55899) ASSIGNED TO THIS PROCEDURE: Typically, therapeutic sperm retrievals are preformed in a surgical place of service with general anesthesia and open surgical techniques. However, we perform this procedure in the office with local anesthesia and percutaneous approach. This approach saves the patient the risk of general anesthesia and open surgery. However, it must be understood sperm retrievals performed with this practice are therapeutic procedures; NOT to be confused with diagnostic/pathologic procedures or simple fine needle aspirates. The retrieval procedure is performed in connection with Intra Cytoplasmic Sperm Injection [ICSI].

Testesimplantinstructions

# **PRE-OPERATIVE INSTRUCTIONS FOR TESTICULAR IMPLANT SURGERY**

1. Every day for one week prior to your surgery you must wash penis and scrotum with **Hibiclens** (Chlorhexidine) soap. You can buy it without a prescription at any local pharmacy.
2. As of midnight on the day of your scheduled surgery, you may not have anything to eat or drink, including water. If you are instructed to take any medication on the morning of your surgery, you may do so with only a sip of water.
3. Do not shave or trim any hair in the genital region within one week of surgery.

# **DR. JENKINS’ POSTOPERATIVE INSTRUCTIONS FOR**

# **TESTICULAR IMPLANT SURGERY**

# **YOU ARE TO EXPECT**

1. Pain and tenderness in your scrotum for a few days after surgery.
2. Bruising on your scrotum and penis.
3. You should leave with prescriptions for pain medicine.
4. You should also leave with an appointment for a post-operative visit with Dr. Jenkins in approximately 10 days.

# **INSTRUCTIONS**

1. Keep the “mummy wrap” compression dressings on until Friday evening.
2. Keep the extra gauze in place until Sunday.
3. Keep the scrotal support on for at least one week post-operatively.
4. For the first 2 days use an ice pack inside the scrotal support.
5. Make sure your bowels continue to function normally.
6. You may shower on the Saturday.
7. You may walk around the home and up stairs immediately, but carefully.
8. When sitting elevate your legs.
9. Do not drive until at least 4 days post-op.
10. Do not lift any heavy objects (10 lbs or greater) for at least 2 weeks after surgery.

# **CALL FOR THE FOLLOWING REASONS**

1. Fevers over 101 degrees.
2. Excessive pain.
3. Excessive drainage from your wound, especially blood or pus.

## **CONTACT NUMBERS**

1. For questions during office hours (Mon-Fri. 9am-5pm) call **614-685-6666**
2. For any emergency questions on weekends/outside of office hours, call **614-293-8000** and ask to speak to the resident on-call**.**

Testopelinsertion

**OFFICE PROCEDURE NOTE**

**PREPROCEDURE DIAGNOSIS:** Hypogonadism.

**POSTPROCEDURE DIAGNOSIS:** Hypogonadism.

**PROCEDURE**: Testopel insertion/implant to his {RIGHT/LEFT:22913} flank, \*\*\* pellets implanted.

**SURGEON:** LAWRENCE JENKINS, MD

**Assistant Surgeon:** \*\*\*

**ANESTHESIA:** Local.

**DRAINS:** None.

Labs reviewed, Dose - continued\*\*\*

Last PSA: \*\*\*

Acne \*\*\*

Breast swelling/tenderness \*\*\*

Leg swelling \*\*\*

Energy \*\*\*

Concentration/Mood \*\*\*

Sexual Desire \*\*\*

Erections \*\*\*

The risks/benefits of the procedure were discussed with the patient.

**DESCRIPTION OF PROCEDURE:** The patient was placed in the lateral decubitus position and his skin was prepped with chlorhexadine solution. 10 ml of 2% lidocaine w/sodium bicarb were instilled subcutaneously in a straight fashion. I have personally verified and performed the final check of the medication(s) used in this procedure prior to administration. The following items were included during the verification process for medication(s) administered: see above (drug name/strength/volume/expiration/physical integrity and appearance of the medication).

A 3mm skin puncture was made with an 11 blade. The trochar was placed subcutaneously along the line with ease and without patient discomfort. The sharp stylet was removed and the pellets were placed along the track and positioned using the blunt stylet. Following this, a steri strip was used to close the puncture wound. A 4/4 gauze pad was placed over the wound and a Tegaderm bandage was applied and the patient was repositioned on his opposite side for compression purposes with a roll.

**Today we used the medication from our stock supply and not pre-ordered.**

**PLAN:** The patient was discharged in stable condition to be followed up with serum testosterone levels.

I, Lawrence Jenkins, MD, was present in the room for the entire procedure today.

Testopelinstruct1lab

**Testopel Post-Insertion Care Instructions**

1. Apply ice to the site for 20–30 minutes every hour after insertion, as needed. You may consider taking a pain reliever if discomfort continues. Remember, you might experience tenderness at the site for a few days following insertion. You may experience redness and swelling at the site.
2. Avoid hot tubs, swimming, or full water immersion of the insertion site for 72 hours.
3. The top bandage may be removed after 24-48 hours. The steri-strips bandages will come off naturally after approximately 4-5 days.
4. Avoid strenuous activity and heavy lifting for 24–72 hours.
5. Contact your physician immediately if infection or pellet extrusion is suspected.

**Labs 2 weeks before your next appointment**

**Call your doctor if you experience any of the following:**

1. Discharge from insertion site
2. Dizziness or lightheadedness
3. Excessive redness or swelling
4. Excessive tenderness
5. Chills and/or fever greater than 101.5oF
6. Any other symptoms
7. Nausea or vomiting

**Labs 2 weeks before your next appointment**

Testopelinstruct2lab

**Testopel Post-Insertion Care Instructions**

1. Apply ice to the site for 20–30 minutes every hour after insertion, as needed. You may consider taking a pain reliever if discomfort continues. Remember, you might experience tenderness at the site for a few days following insertion. You may experience redness and swelling at the site.
2. Avoid hot tubs, swimming, or full water immersion of the insertion site for 72 hours.
3. The top bandage may be removed after 24-48 hours. The steri-strips bandages will come off naturally after approximately 4-5 days.
4. Avoid strenuous activity and heavy lifting for 24–72 hours.
5. Contact your physician immediately if infection or pellet extrusion is suspected.

**Labs in 2 weeks and 2 weeks before your next appointment**

**Call your doctor if you experience any of the following:**

1. Discharge from insertion site
2. Dizziness or lightheadedness
3. Excessive redness or swelling
4. Excessive tenderness
5. Chills and/or fever greater than 101.5oF
6. Any other symptoms
7. Nausea or vomiting

**Labs in 2 weeks and 2 weeks before your next appointment**

Tfuq

Acne \*\*\*

Breast swelling/tenderness \*\*\*

Leg swelling \*\*\*

Energy \*\*\*

Concentration/Mood \*\*\*

Sexual Desire \*\*\*

Erections \*\*\*

Time

Today's visit occupied approximately \*\*\* min of my time with greater than 50% in direct face-to-face consultation spent counseling and coordinating care including discussing my findings with the patient, explaining the rationale for my recommendations and answering questions.

Trusnobiopsy

**TRUS OF PROSTATE**

**Preoperative diagnosis**

Low semen volume

**Postoperative diagnosis**

Same

**Procedure**

1. Transrectal ultrasound of the prostate

**Attending Surgeon**

Lawrence Jenkins, MD, MBA

**Anesthesia**

2% lidocaine jelly, intrarectal instillation, 10mL

**Complications**

None

**Specimen**

None

**Indications**

Mr. @LNAME@ is a @AGE@ male with low semen volume. He presents for prostate ultrasound to evaluate for ejaculatory duct obstruction.

**Procedure**

The patient was positioned and prepped in a left lateral position with lower extremities flexed. Lidocaine jelly, 2%, was injected per rectum. A digital rectal exam was performed which demonstrated a \*\*\* gram prostate without nodules or induration. The GE E8CS rectal ultrasound probe was slowly introduced into the rectum without difficulty. The prostate and seminal vesicles were inspected systematically using cross and sagittal views with the ultrasound. There were \*\*\* hypoechoic areas within the prostate. A median lobe was \*\*\* seen. The dimensions of the prostate were measured to be \*\*\*cm X \*\*\*cm X \*\*\*cm, for a calculated volume of \*\*\* mL. The seminal vesicles appeared \*\*\* measuring the superior/inferior borders Right \*\*\* cm and Left\*\*\*cm.. The rectal ultrasound probe was removed. The patient tolerated the procedure well.

**Plan**

1. \*\*\*

Lawrence Jenkins, MD, MBA was present in the procedure room for the entire procedure.

txstentpull

**Preoperative diagnosis**

Hx of renal transplant

**Postoperative diagnosis**

Hx of renal transplant

**Procedure**

Flexible cystourethroscopy with stent removal

**Attending surgeon**

Lawrence Jenkins, MD, MBA

**Resident**

\*\*\*

**Anesthesia**

2% lidocaine jelly intraurethrally

**Complications**

None

**Indications**

@AGE@ @SEX@ who is status post renal transplant who presents for stent removal.

**Procedure**

Detailed information of all possible complications and side effects were discussed with the patient. Informed consent was obtained. Patient was given one dose of antibiotics. The patient was placed in supine position and a timeout was performed. The patient was prepped and draped in sterile fashion. Next, 2% lidocaine jelly was bluntly injected per urethra without difficulty. The 14 French flexible cystoscope was passed through the urethra and into the bladder. The stent\*\*\* was visualized, grasped and removed in its entirety. The patient tolerated the procedure well.

**Plan**

RTC PRN

Lawrence Jenkins, MD, MBA was in the procedure room for the entire duration of the procedure.

Ljvasprocedure

**Preoperative Diagnosis:**                              Elective sterilization

**Postoperative Diagnosis:**                            Elective sterilization

**Operation:**                                                 Bilateral no-scalpel vas ligation

**Attending Surgeon:**  Lawrence C. Jenkins, MD

**Assistant Surgeon:** \*\*\*

**Anesthesia**:                                                   Local 0.5% bupivicaine \*\*\*mL

**Anesthesiologist**:                                          None

**Location:**                                                       Urology procedure room

**Surgical Service:**                                          Urology

**Specimens:**  none

**Complications:**  \*\*\* none

**Estimated blood loss:** 2\*\*\* mL

**Indications**:  Mr. @NAME@ is a @AGE@-year-old, who presented to the office desiring elective sterilization.  The risks and benefits were discussed with the patient and informed consent was obtained.  He presents today for the procedure.

**Procedure:**

The patient was brought to the procedure room and placed in supine position.  His scrotum was prepped with Hibiclens and he was draped sterilely in the usual fashion. A timeout was performed.

The median raphe and both vasa were infiltrated with local anesthetic using a high-pressure jet injector.  The median raphe was punctured, spread and the right vas delivered. The vas was transected and the lumina were cauterized for a distance of a 0.5 cm with cautery in either direction.  Fascial interposition was accomplished by sealing the abdominal end in the vasal sheath with a single Weck Hemoclip.  The right vas was returned to the scrotum.    The left vas was brought up through the same puncture wound and an identical procedure was performed.  The left vas was returned to the scrotum. There was minimal bleeding.  No sutures were required.  The puncture wound contracted. Bacitracin was placed on the puncture wound  Sterile dressings were held in place by scrotal supporter.  The procedure was terminated with the patient in satisfactory condition.

It was reiterated to the patient that he would remain fertile for sometime and should present to the lab for a post-vasectomy semen analysis to confirm sterility.  The patient expressed understanding.

Lawrence Jenkins, MD, was present in the room for the entire procedure today.

Ljvasrevediscuss

Today we discussed the procedure of vasectomy reversal and the expected outcomes. We discussed the cost (about $8000) and the alternatives including donor sperm and IUI (about $600-1300), IVF with sperm extraction (about $11,000) or adoption. We discussed the need for sperm extraction for IVF and the cost associated with this ($1000-$3000) We discussed the expected recovery and time to return to normal activities. We discussed the possibility of need for vasoepididymostomy and how this is determined intraoperatively. We discussed the surgical procedure and recovery time, including abstaining from ejaculation for 28 days. We discussed the use of ice post-operatively and the risk of restenosis. We discussed the likely success rates for sperm returning to the ejaculate as well as pregnancy rates. This was compared with sperm harvest and IVF as well. I discussed that success was not 100% and depended on multiple factors. He wishes to think more and let us know.

Vvopnote

SURGEON: Lawrence Jenkins, MD

ASSISTANT: \*\*\*

PREOPERATIVE DIAGNOSIS: Bilateral obstruction of the vas deferens and epididymis and chronic congestive epididymitis secondary to obstruction.

POSTOPERATIVE DIAGNOSIS: Bilateral obstruction of the vas deferens and epididymis and chronic congestive epididymitis secondary to obstruction.

OPERATION: Bilateral scrotal exploration (55110), bilateral microsurgical vasotomy and vasogram (55300) bilateral microsurgical vasovasostomy (55400, 69990), intraoperative microscopic evaluation of vasal fluid (89257)

ANESTHESIA: General anesthesia.

DESCRIPTION OF PROCEDURE:

After induction of adequate general anesthesia, the patient was placed in supine position, prepped and draped in the usual fashion. The bladder was catheterized with a 16-French foley catheter yielding clear urine.

A 3.5 cm high midline scrotal incision was made. The dartos muscle was divided with the Bovie electrocautery, and the right testis was delivered extravaginally. A strictured fibrotic segment of vas was identified in the proximal portion of the vas deferens. The vas was surrounded above and below the strictured portion with a Babcock clamp and replaced with vessel loops.

The operating microscope was brought into the field. Under 10 power magnification, the fibrotic segment was dissected out of the convoluted vas. The tunica vaginalis needed to be opened in order to access the convoluted vas which was dissected to the vaso-epididymal junction. The abdominal end was dissected off the internal spermatic fascia to the level of the external inguinal ring. Under 25 power magnification with a 2.0 straight slotted nerve holding clamp and an salami knife, the testicular end of the vas was transected.

White colored fluid was seen coming from the testicular end and we used a wet prep to obtain a sample of fluid. The vasal fluid was placed on a slide covered with a cover slip and examined by myself under the separate 40-100 power bench microscope. This revealed progressive motile sperm and other sperm parts.

The vas was recut several times since it was deep in the convoluted vas until finally a round lumen directed straight for 2-3 mm was identified. The vasal vessels on the testicular end were were coagulated with the bipolar cautery. The abdominal end was then transected above the stricture and no lumen was found. It was transected again until lumen was identified. This was cannulated with a vessel dilator and a 24-gauge Angiocath sheath. A saline vasogram was then performed revealing complete patency of the abdominal end of the left vas deferens.

The ends of the vasa were then placed in the Goldstein Microspike clamp and the field isolated with a rubber dam. Under 25 power magnification, the cut ends of the vasa were dried with Weck-cels, and 6 micro-dots were placed on the each side indicating the exit points of the mucosal sutures. The mucosa was then re-approximated with 6 interrupted sutures of double-armed 10-0 monofilament nylon. The muscularis was then re-approximated with 6 interrupted sutures of 9-0 single-armed monofilament nylon, the adventitia with 6 interrupted sutures of 9-0 monofilament nylon and the sheath with a 4 interrupted sutures of 8-0 nylon. After good hemostasis had been obtained, the testis was returned to the scrotum. On this side, the tunica vaginalis closed with 3-0 polysorb suture.

Attention was then turned to the left side where the dartos was opened using electrocautery and the testicle delivered within the tunica. On this side, vasogram also revealed complete patency of the abdominal portion, and after a gush of white colored fluid sperm parts, heads, and some short tails, but no motile sperm were found in the testicular fluid. An identical microsurgical vasovasostomy was performed on the left side.

The dartos muscle was closed with running sutures of 3-0 Polysorb; the skin with a interrupted horizontal mattress suture of 4-0 Chromic. The incision was infiltrated with 0.25% Marcaine. Antibiotic ointment was placed on the wound. The catheter was removed at the end of the procedure.

A mummy wrap and sterile fluff dressings were held in place with a scrotal supporter. The procedure was terminated with the patient in satisfactory condition

Dr. Jenkins was scrubbed throughout the entire procedure and performed the entire procedure. Total operating time was approximately 4 hours.

Nbburied

I discussed buried penis with the patient and reviewed all management options.

We discussed that adult buried penis is closely related to obesity, rapid weight loss or other local conditions such as Lichen Sclerosus or penoscrotal Lymphedema. We specifically discussed that this is not a cosmetic procedure and goal is to restore function and allow unobstructed voiding, restore sexual function and decrease risk of infection.

I told him and depending on the severity of his condition medical and surgical options are available. Local topical steroids are effective in the case of Lichen Sclerosus however severe instances will require surgery. We discussed that several decisions are made intraoperatively. It can range from ventral/dorsal slit if the condition is mild with adequate penile skin, removal of diseased tissue (escutcheonectomy, scrotectomy) with or without suprapubic defatting, scrotoplasty and ultimately skin grafting of the penis or scrotum. I told him that urethral/meatal stricture is common once penis is unburied and that require separate treatment strategy if present.

I outlined the hospital course, use of drains, antibiotics, wound care and postop activity restrictions depending on each surgical approach. We reviewed wound complications including soft tissue infection, graft loss, disease recurrence or need for additional procedures. We also discussed that given other comorbidities, there is higher risk of surgical complications such as pulmonary embolus, DVT, pulmonary compromise, sepsis and death. We then discussed the importance of optimizing his concomitant medical conditions if present such as hypertension, diabetes, depression, and obesity and their impact on successful operation and improved wound healing.

He asked excellent questions and I answered them all to his satisfaction. After a long conversation he elected to \*\*\*

Ljvxleft

**Surgeon:**  Lawrence Jenkins, MD

**Assistant Surgeon:** \*\*\*

**Preoperative Diagnosis:** Left varicocele

**Postoperative Diagnosis:** Left varicocele

**Operation:**  Left microsurgical varicocelectomy (55530), with intraoperative ultrasound assistance (76998)

**Anesthesia:** General

**Procedure:** The patient was brought to the operating and was laid supine upon the table and had the administration of general anesthesia.Ancef 2g was given IV.

**Left varicocelectomy:** A small left inguinal incision was made overlying the left external inguinal ring. The incision was deepened down through Camper's and Scarpa's fascia with Bovie electrocautery, with tissues separated by Kelly clamps and subsequently with Army/Navy retractors. The superficial epigastric arteries and veins were identified and ligated with 3-0 silk suture. The external oblique aponeurosis was identified, and the spermatic cord was seen exiting the left external inguinal ring. The region around the cord was infiltrated using 5 mL of 0.5% bupivacaine. The spermatic cord was grasped with a Babcock clamp and delivered out of the wound and placed over a Penrose drain.

The operating microscope was brought into the field. Under 10x magnification, the external and internal spermatic fascias were opened in the direction of their fibers. Under 15 power magnification and with the aid of a microdoppler, two\*\*\* large internal spermatic arteries was identified, dissected free of tiny surrounding veins, surrounded with a vessel loop and preserved. Multiple lymphatics were identified and preserved. The vas deferens and its vessels were inspected and were preserved. All internal spermatic veins numbering approximately 15 (4\*\*\* very large) were doubly ligated with 4-0 silk or clipped with micro-clips and divided. The cord was run again over index finger and any remaining veins ligated and divided. External spermatics and muscle body were clipped and preserved with care taken to avoid vasal vessels. The testis was not delivered into the wound, but all external spermatic veins on the floor of the inguinal canal were cauterized and divided. The vessel loops were removed from the arteries, and the spermatic cord was then returned to its bed.

**Closure:** Scarpa's and Camper's fascia were closed with interrupted sutures of 3-0 Polysorb. Biosyn (4-0) was used for subcuticular closure of skin, and this was reinforced with dermabond after the wound was infiltrated with 0.5% bupivacaine.

Sterile dressings were placed on the wound. A scrotal supporter was placed. The procedure was terminated with the patient in satisfactory condition and no complications. Total operating time was approximately 2 hours. Dr. Jenkins was present throughout the entire procedure and performed all critical portions of the entire operation.

Ballpain

Mr. @LNAME@ is a @AGE@ male with history of \*\*\* who presents with intermittent and chronic \*\*\* testicular pain.

Quality: Sharp\*\*\* Dull\*\*\*

Provocative factors: Activity\*\*\* makes it worse

Palliative factors: Rest\*\*\* makes it better

Radiation: Along \*\*\*

Severity: \*\*\*/10 currently and \*\*\*/10 at its worst

Time: Pain started \*\*\* weeks \*\*\* months \*\*\* years ago

The patient has previously tried the following treatment(s):

- \*\*\* with \*\*\*no benefit.

No history of UTIs, STIs, kidney stones, recent trauma or injury.

He {Does/does not:20985} report recent constipation.

The patient {Does/does not:20985} have interest in future fertility.

Oldcarrts

Pain

Onset: {Pain onset:10016558}

Location: \*\*\*

Duration: \*\*\*

Characterization: {Pain Quality:19357}

Aggravating Factors: \*\*\*

Alleviating Factors: {Pain (activities that relieve):11563}

Radiation: \*\*\*

Temporal: {Pain frequency pattern:10015955}

Severity: {PAIN SCALE 1-10:19356}

Orurs

**Preoperative diagnosis**

{LEFT/RIGHT CAP:19321} kidney stone

**Postoperative diagnosis**

{LEFT/RIGHT CAP:19321} kidney stone

**Procedure performed**

1. Flexible cystoscopy, {RIGHT/LEFT:19628} retrograde pyelogram with ureteral stent placement

2. {Right, left-initial cap:1005607} ureteroscopy with holmium-YAG laser lithotripsy and basket extraction of stone fragments

3. Fluoroscopy time < 1 hour with interpretation of images

**Attending surgeon**

@ATTPROV@

**Anesthesia**

General

**Complications**

None

**Specimen**

Stone fragments for biochemical analysis

**Findings**

Urethroscopy revealed no strictures or other abnormalities.

Cystoscopy revealed no tumors, stones or other mucosal abnormalities.

{LEFT/RIGHT CAP:19321} retrograde pyelogram revealed a delicate system with identification of the stone seen on pre-op imaging. No other filling defects and caliber of {left/right:311354} ureter was smooth and normal.

**Indications**

@AGE@ @SEX@ agreed to undergo the above named procedure after discussion of the alternatives, risks and benefits. Informed consent was obtained.

**Procedure**

The patient was taken to the operating room and placed supine on the operating table. Pre-operative antibiotics were administered. Bilateral lower extremity SCDs were placed. After induction of general anesthesia the patient was positioned in dorsal lithotomy, prepped and draped in a sterile fashion. A time-out was performed.

A 14-French flexible cystoscope was passed carefully via urethra into the bladder. The {left/right:311354} ureteral orifice was identified and a Sensor wire was passed retrograde to the level of the kidney and confirmed by fluoroscopy. The flexible scope was off-loaded and the bladder emptied with a straight catheter. A 5-French open-ended was passed over the wire and the wire removed. A retrograde pyelogram was performed by slowly injecting 5 mL of 50% Omnipaque contrast via the 5-French catheter with findings described above. A sensor wire was replaced and the 5-French removed. An 8-10 coaxial dilator was passed without difficulty. The 8-French portion was removed and an Amplatz super-stiff was placed to the level of the renal pelvis confirmed by fluoroscopy. The 10-French dilator was then withdrawn. The Sensor wire was clipped to the drape as a safety wire. A 12-14, \*\*\*-cm access sheath was advanced over the super-stiff wire to level of the UPJ under direct fluoroscopic guidance. The inner stylet and super-stiff wire were removed and the sheath was sutured in place with 2-0 silk. The kidney was entered with the Olympus URF-P5 flexible ureteroscope. The kidney stone was identified and fragmented with a 200-micron holmium YAG laser fiber at laser settings of 0.8 joules and a frequency of 8 Hz. The fragments were basket extracted. At the completion of the procedure, all clinically significant fragments were removed and only dust-like fragments remained. The access sheath was removed under direct vision. Ureteral edema but no obvious obstruction was present. A 5-French catheter was passed over the safety wire and the wire withdrawn. Contrast was injected into the renal pelvis via the 5-French open-ended catheter. A super-stiff wire was placed and confirmed by fluoroscopy. A 6 x \*\*\* French stent was positioned with the upper end in the upper pole and the lower in the bladder confirmed by fluoroscopy. The bladder was emptied and the procedure was complete. The patient tolerated the procedure well and was stable throughout.

@ATTPROV@ was present in the procedure room the entire duration of the case.

Ursdischarge

**Home Care After Ureteroscopy, Laser Lithotripsy and Stent Placement**

The following instructions will help you care for yourself, or be cared for upon your return home today.

These are guidelines for your care right after surgery only.

**Diet**

Drink plenty of liquids and eat light meals today.

Start your regular diet tomorrow.

**Activity**

Start normal activities in twenty-four (24) hours.

**Wound Care and Hygiene**

No restrictions, start normal routine.

**Anesthesia Precautions & Expectations**

After anesthesia, rest for 24 hours.

Do not drive, drink alcoholic beverages or make any important decisions during this time.

General anesthesia may cause a sore throat, jaw discomfort or muscle aches.

These symptoms can last for one or two days.

**What to Expect after Surgery**

Mild pain with voiding.

Frequency or urgency.

Bladder cramps.

Minimal bleeding with voiding.

**Call your Doctor**

Passing clots in urine preventing bladder emptying

Severe pain not controlled by oral medication

Temperature above 101.5 degrees

Inability to urinate within eight (8) hours after surgery

**After Stent Placement**

It is common to have blood tinged urine for 3-5 days.

It is common to have pain in your side and in your back when you urinate for 3-5 days.

It is common to have urgency with urination.

This is a temporary stent and will need to be pulled at the next appointment.

**Follow up Appointment**

\*\*\*

**Other Contacts**

Urology Department (614) 293-8155

After hours and on weekends, if you have questions or problems, call (614) 293-8000 and ask the hospital operator to page the urology resident on call.

If it is a question or problem that can wait until business hours, call the clinic phone number listed above when the clinic is open during weekdays, 8am-4pm.

If you are unable to reach your doctor and it is a medical emergency call the OSU Emergency Department at (614) 293-8333 or dial 911.

Rtneststone

**Chief Complaint**

History of kidney stones

**HPI**

Mr\*\*\*. @LNAME@ is a @AGE@ @SEX@ with history of \*\*\*-containing kidney stones following up with \*\*\*.

The patient last underwent {left/right:311354} PCNL\*\*\*URS on \*\*\*/201\*\*\*.

Current Prevention Strategies

Medical management for stone prevention includes the following: \*\*\*

Dietary management for stone prevention includes the following: \*\*\*

The patient currently denies flank pain or new lower urinary tract symptoms.

Since the last visit the patient has had the following changes with medical history: \*\*\*

**Review of Systems**

Constitutional: No fevers or chills

Skin: Negative for rash

Endocrine: No heat/cold intolerance

Gastrointestinal: Negative for constipation, nausea or vomiting

Genitourinary: \*\*\*Negative for gross hematuria or dysuria.

Musculoskeletal: Negative for flank pain

Neurological: Negative for frequent headaches or dizziness

Lymph/Heme: Negative for easily bruises / bleeds

**Physical Exam**

@VS@

Constitutional: NAD, WDWN.

Cardiovascular: Regular rate.

Pulmonary/Chest: Respirations are even and non-labored bilaterally.

Abdominal: Soft. No distension, tenderness, masses or guarding. No CVA tenderness.

Extremities: MOE x 4, Warm. No clubbing. No cyanosis.

Skin: Pink, warm and dry. No rashes noted.

**UA- Point of care**

@LASTLABX(APPEARANCE,COLOR,KETONES,SPECIFICGRAV,BLOOD,PH,PROTEIN,UROBILINOGEN,NITRITE,LEUKOCYTE,ESTERASE,BACTERIA,AMORPHOUS,CASTSQUANTIT,SQUAMOUSEPIS,RENALEPIS,CRYSTALS,URINECOMMENT)@

**Labs**

@LASTLABOSUSHORT(PTH,CALCIUM,CALCIUMPTH,CALCIUMIONIZ,PHOSPHORUS)@

@LASTLABOSUSHORT(URIC)@

**Stone Analysis**

@LASTLABX(STONE1STCONS,STONE2NDCONS,STONE3RDCONS)@

**Radiographic Studies**

KUB today reviewed revealing \*\*\*.

RUS today reviewed revealing \*\*\*.

CT today reviewed revealing \*\*\*.

**Assessment**

Mr\*\*\*. @LNAME@ is a @AGE@ @SEX@ with history of \*\*\*-containing kidney stones following up with \*\*\*.

**Plan**

1. Encourage consistent hydration of 2.5 Liters of fluid daily.

2. \*\*\*

Rtnhematuria

**Chief Complaint**

Microscopic\*\*\*Gross\*\*\* hematuria

**HPI**

Mr. @LNAME@ is a @age@ male with history of \*\*\* who presents with microscopic\*\*\*gross\*\*\* hematuria.

History of smoking? {YES (DEF) /NO:19695:o}

History of second-hand smoking exposure? {YES (DEF) /NO:19695:o}

History of chemotherapy? {YES (DEF) /NO:19695:o}

History of radiation? {YES (DEF) /NO:19695:o}

History of kidney or bladder stones? {YES (DEF) /NO:19695:o}

History of frequent urinary tract infections? {YES (DEF) /NO:19695:o}

He currently denies fevers, chills, nausea, vomiting, constipation or flank pain.

**Past Medical History**

@CAPHE@ @PMHP@

**Past Surgical History**

@CAPHE@ @PSHP@

**Medications**

@capHE@ @CMEDP@

**Allergies**

@capHE@ @ALLERGYP@

**Social History**

@capHE@ @SOCHXP@

**Family History**

@CAPHE@ has no family history of prostate, bladder or kidney cancer

@CAPHE@ has no family history of kidney stones

**Review of Systems**

Constitutional: No fevers or chills

Skin: Negative for rash

Endocrine: No heat/cold intolerance

Cardiovascular: Negative for chest pain or dyspnea on exertion

Respiratory: Negative for shortness of breath or wheezing

Gastrointestinal: No constipation, nausea or vomiting

Genitourinary: \*\*\*Negative for new lower urinary tract symptoms or dysuria.

Musculoskeletal: No flank pain

Neurological: Negative for frequent headaches or dizziness

Lymph/Heme: Negative for leg swelling or calf pain.

**Physical Exam**

@VS@

Constitutional: NAD, WDWN.

HEENT: NCAT. Conjunctivae normal. MMM.

Cardiovascular: Regular rate.

Pulmonary/Chest: Respirations are even and non-labored bilaterally.

Abdominal: Soft. No distension, tenderness, masses or guarding. No CVA tenderness.  
Neurological: A + O x 3. Cranial Nerves II-XII grossly intact.

Extremities: MOE x 4, Warm. No clubbing. No cyanosis.

Skin: Pink, warm and dry. No rashes noted.

Psychiatric: Normal mood and affect

**\*\*\* Genitourinary**

Penis: {Desc; circumcised/uncircumcised:5705::"circumcised"} penis, glans normal, no penile discharge. No rashes/lesions.

Testes: descended bilaterally, no masses, {Desc; tender/non:10087} to palpation. Remainder of scrotal contents normal. No hernia appreciated.

Rectal: Normal tone, no masses.

Prostate: {NUMBERS; 5-50 BY 5:60395} grams. Symmetric, non-tender, anodular and no induration.

**Labs**

\*\*\*

**Radiologic Studies**

\*\*\*

**Assessment**

@age@ male who presents with microscopic\*\*\*gross\*\*\* hematuria.

Risk factors include \*\*\*.

In order to complete the hematuria work up we need to perform a flexible cystoscopy and acquire upper tract imaging.

**Plan**

1. We discussed the indications for diagnostic flexible cystoscopy to be performed at the next clinic visit.

2. \*\*\*

Rtnnewpsa

**Chief Complaint**

Elevated PSA

**HPI**

Mr. @LNAME@ is a @age@ male who presents with an elevated PSA to \*\*\*.

He {Does/does not:20985} have a family history of prostate cancer.

Past GU history is negative for BPH, frequent UTIs, gross hematuria, stones or other renal diseases.

He denies shortness of breath, leg swelling, calf pain or bone pain.

**Past Medical History**

@capHE@ @PMHP@

**Past Surgical History**

@capHE@ @PSHP@

**Medications**

@capHE@ @CMEDP@

**Allergies**

@capHE@ @ALLERGYP@

**Social History**

@capHE@ @SOCHXP@

**Family History**

@CAPHE@ has no family history of prostate, bladder or kidney cancer

**Review of Systems**

Constitutional: No fevers or chills

Skin: Negative for rash

Endocrine: No heat/cold intolerance

Cardiovascular: Negative for chest pain or dyspnea on exertion

Respiratory: Negative for shortness of breath or wheezing

Gastrointestinal: No constipation, nausea or vomiting

Genitourinary: Negative for new lower urinary tract symptoms\*\*\*, current gross hematuria or dysuria.

Musculoskeletal: No flank pain

Neurological: Negative for frequent headaches or dizziness

Lymph/Heme: Negative for leg swelling or calf pain.

**Physical Exam**

@VS@

Constitutional: NAD, WDWN.

HEENT: NCAT. Conjunctivae normal. MMM.

Cardiovascular: Regular rate.

Pulmonary/Chest: Respirations are even and non-labored bilaterally.

Abdominal: Soft. No distension, tenderness, masses or guarding. No CVA tenderness.  
Neurological: A + O x 3. Cranial Nerves II-XII grossly intact. Normal gait.

Extremities: MOE x 4, Warm. No clubbing. No cyanosis.

Skin: Pink, warm and dry. No rashes noted.

Psychiatric: Normal mood and affect

**Genitourinary**

Penis: {Desc; circumcised/uncircumcised:5705::"circumcised"} penis, glans normal, no penile discharge. No rashes/lesions.

Testes: descended bilaterally, no masses, {Desc; tender/non:10087} to palpation. Remainder of scrotal contents normal. No hernia appreciated.

Perineum: No perineal pain with palpation.

Rectal: Normal tone, no masses.

Prostate: {NUMBERS; 5-50 BY 5:60395} grams. Symmetric, non-tender, anodular and no induration.

**IPSS**

@flow[5103@

@flow[5106@

**SHIM**

@flow[5301@

**Labs**

**\*\*\***

@BRIEFLAB(psa:\*)@

**Post-Void Residual**

A post-void residual was measured by ultrasonic bladder scanner.

@flow[6347@

**Radiographic Studies**

\*\*\*

**Assessment**

Mr. @LNAME@ is a @age@ male who presents with elevated PSA.

I explained to the patient that an elevated PSA is a marker of risk of prostate cancer and a prostate biopsy would be the next step in diagnosis. I explained that sampling error can occur with any biopsy and there is a risk of potentially missing a cancer that may be present.

His risk stratification based on data from the prostate cancer prevention trial reveals a \*\*\*% chance of biopsy-detectable prostate cancer with a \*\*\*% chance of having a high-grade disease.

I discussed the risks, benefits, and alternatives to prostate biopsy, including hematuria, hematochezia, and hematospermia. I also discussed the risk of diagnosing a clinically-insignificant prostate cancer. I discussed the risks of sepsis, which can be minimized by prophylactic antibiotics.

**Plan**

1. Recommended TRUS biopsy of prostate

I provided a prescription for \*\*\* po bid for \*\*\* days to start the day prior to biopsy.  
I informed him to hold \*\*\* for \*\*\* days prior to biopsy.

Rtnorchradi

**Preoperative diagnosis**

{LEFT/RIGHT CAP:19321} testicular mass

**Postoperative diagnosis**

{LEFT/RIGHT CAP:19321} testicular mass

**Procedure performed**

{LEFT/RIGHT CAP:19321} radical orchiectomy

**Attending surgeon**

@ATTPROV@

**Anesthesia**

General endotracheal anesthesia

\*\*\* mL bupivicaine 0.5% local injection

**EBL**

10 mL

**Complications**

None

**Specimen**

{LEFT/RIGHT CAP:19321} testicle and spermatic cord

**Indications**

@AGE@ @SEX@ agreed to undergo the above named procedure after discussion of the alternatives, risks and benefits. He was found to have a {left/right:311354} testicular mass that is highly suspicious for malignancy. He understands there is a possibility of this finding being benign. Informed consent was obtained.

**Procedure**

The patient was taken to the operating room and placed supine on the operating table. Pre-operative antibiotics were administered. Bilateral lower extremity SCDs were placed. After induction of general anesthesia the patient was maintained in supine position. The patient was prepped and draped in a sterile fashion and a time-out was performed.

A horizontal inguinal incision was made superior to the external ring with a scalpel. Dissection was carried through the subcutaneous fat and Scarpa's fascia with electrocautery. The external ring was dissected free of fat with blunt dissection. The external oblique fascia was incised cephalad to the external inguinal ring and subsequently opened with Metzenbaum scissors. The ilioinguinal nerve was identified and carefully retracted and excluded from the wound laterally. The inguinal cord was isolated and secured tightly with a Penrose in a 360 degree fashion. We dissected the testis free from attachments within the scrotum into the inguinal wound. The gubernacular attachments were bluntly dissected with electrocautery, taking care not to burn the scrotal skin. The most cephalad aspect of the cord above the level of the Penrose was divided into the vas and non-vas structures. Using blunt dissection a window was developed between these 2 structures and clamped cephalad and caudad. High ligation of the cord was performed with Metzenbaum scissors and the testis and cord was passed off to the field as one specimen for permanent pathology. An 0 silk free tie and 2-0 silk stick tie were placed proximally on each individual packet to assure hemostasis. All suture ties were cut long. The clamps were released and the cord stump investigated to assure hemostasis. There was no sign of bleeding. The cord stump and long sutures were reduced into the retroperitoneum. The inguinal wound and the scrotum were copiously irrigated with sterile saline. The oblique fascia was closed in a running fashion with 2-0 Vicryl suture. Scarpa's fascia was closed in a running fashion with 3-0 Vicryl suture. The skin was closed in a running subcuticular fashion with 4-0 Biosyn suture and Dermabond was applied. Scrotal support was placed with fluffs and a jock strap.

The patient was awakened, extubated and transferred to recovery unit without difficulty.

At the end of the procedure all instrument, needle and sponge counts were correct x 2.

@ATTPROV@ was present in the procedure room the entire duration of the case.

Rtnorchsimple

**Preoperative diagnosis**

{LEFT/RIGHT CAP:19321} epididymo-orchitis

**Postoperative diagnosis**

{LEFT/RIGHT CAP:19321} epididymo-orchitis

**Procedure performed**

{LEFT/RIGHT CAP:19321} simple orchiectomy

**Attending surgeon**

@ATTPROV@

**Anesthesia**

General endotracheal anesthesia

\*\*\* mL bupivicaine 0.5% local injection

**EBL**

10 mL

**Complications**

None

**Specimen**

{LEFT/RIGHT CAP:19321} testicle and spermatic cord

**Indications**

agreed to undergo the above named procedure after discussion of the alternatives, risks and benefits. He was found to have a {left/right:311354} testicular mass that is highly suspicious for malignancy. He understands there is a possibility of this finding being benign. Informed consent was obtained.

**Specimen**

Left testicle and partial spermatic cord sent for permanent

**Indications**

@AGE@ male agreed to undergo the above named procedure after discussion of the alternatives, risks and benefits.

He was found to have {RIGHT/LEFT:21423} epididymo-orchitis that was refractory to conservative management with antibiotics and pain medication.

Informed consent was obtained after discussion of the patient's options.

**Procedure**

The patient was taken to the operating room and placed supine on the operating table. Pre-operative antibiotics were administered. Bilateral lower extremity SCDs were placed. After induction of general anesthesia the patient was maintained in supine position. The patient's previous cathter was removed. The patient was prepped and draped in a sterile fashion and a time-out was performed.

A horizontal, left scrotal incision was made with a scalpel. Dissection was carried through the subcutaneous fat and Dartos fascia with electrocautery and blunt dissection. The gubernacular attachments were bluntly dissected with electrocautery, taking care not to burn the scrotal skin. The cord was clamped with a Kelly. The cord distal to the clamp was dissected into two packets, one containing the vas deferens and the other containing the testicular artery. An 0 silk free tie and 2-0 silk stick tie were placed proximally on each individual packet to assure hemostasis. The clamps were released and the cord stump investigated to assure hemostasis. There was no sign of bleeding. The scrotal wound was copiously irrigated with sterile saline. Darto's was closed in a running fashion with 3-0 Vicryl suture. The skin was closed in a running mattress fashion with 3-0 chromic suture. Scrotal support was placed with fluffs and a jock strap.

The patient was awakened, extubated and transferred to recovery unit without difficulty.

At the end of the procedure all instrument, needle and sponge counts were correct x 2.

@ATTPROV@ was present in the procedure room the entire duration of the case.

Rtnpenilefracture

**Preoperative diagnosis**

Penile injury

**Postoperative diagnosis**

Penile fracture

**Procedure performed**

Flexible cystoscopy

Penile exploration and repair of penile fracture

**Attending surgeon**

\*\*\*

**Anesthesia**

General LMA

**EBL**

<5mL

**Complications**

None

**Specimen**

None

**Indications**

23 y.o. male agreed to undergo the above named procedure after discussion of the alternatives, risks and benefits.

He was seen in the ED after sustaining an injury to his penis during sexual activity.

He stated he felt a pop and experienced immediate detumescence with penile pain.

He was found to have penile bruising suspicious for a penile fracture.

We discussed the surgery in detail today including the risks including, but not limited to, infection, bleeding, injury to adjacent structures including the urethra, issues with wound healing, loss of sensation in the glans, appearance of decrease in penile size and erectile dysfunction. He was counseled on risk of ED if no surgery and that surgery does not guarantee prevention of potential development of ED.

The patient was scheduled and consented for penile exploration with repair and cystoscopy in the OR.

**Findings**

Cystoscopic findings included one right and left ureteral orifice in the normal anatomic position with normal bladder mucosa and no tumors, masses or stones. The urethral urothelium was within normal limits with no strictures. There was not a prominent median lobe. The lateral lobes were not obstructive in appearance. Urethroscopy revealed no urethral injury.

Penile exploration revealed a \*\*\*cm laceration to the \*\*\* corpora.

**Procedure**

The patient was taken to the operating room and placed supine on the operating table. Pre-operative antibiotics were administered. Bilateral lower extremity SCDs were placed. After induction of general anesthesia the patient was maintained in supine position. The patient's genitalia was trimmed, prepped and draped in a sterile fashion and a time-out was performed.

The 14F flexible cystoscope was lubricated and gently placed through the penile urethra and into the bladder. The bladder was completely visualized. The cystoscope was retroflexed and the bladder neck and prostate visualized. The cystoscope was slowly withdrawn while visualizing the urethra and the procedure terminated. A 16F Foley was then placed in the patient's urethra.

A scalpel was used to incise the previous circumcision scar circumferentially. With the aid of electrocautery and a hemostat the shaft skin was pulled proximal in order to deglove the penis. Bleeding vessels were cauterized. The corpora defect was identified in the are described above. 3-0 Polysorb was used to close the defect in a running fashion. The NVB were bluntly dissected and rolled medially so as to avoid being incorporated in the closure of the defect. An artificial erection was performed using a tourniquet proximally and injecting sterile saline for injection, 40mL. No leak was identified. The proximal and distal shaft skin was reapproximated using interrupted 3-0 chromic suture. Ointment with gauze and Coban wrap were loosely applied to the incision. The cathter was removed. The patient was awakened, extubated and taken to recovery unit without difficulty.

At the end of the procedure all instrument, needle and sponge counts were correct x 2.

\*\*\* was present in the OR for the critical portions of the procedure and was physically available for the noncritical portions.

Rtnurssemirigid

**Preoperative diagnosis**

{LEFT/RIGHT CAP:19321} ureteral stone

**Postoperative diagnosis**

{LEFT/RIGHT CAP:19321} ureteral stone

**Procedure performed**

1. Flexible cystoscopy

2. {LEFT/RIGHT CAP:19321} retrograde pyelogram

3. {LEFT/RIGHT CAP:19321} ureteroscopy with holmium-YAG laser lithotripsy and basket extraction of stone fragments

4. {LEFT/RIGHT CAP:19321} ureteral stent placement

5. Fluoroscopy time < 1 hour

**Attending surgeon**

@ATTPROV@

**Anesthesia**

General

**Complications**

None

**Specimen**

Stone fragments for biochemical analysis

**Findings**

Cystoscopy revealed no tumors, stones or other mucosal abnormalities.

Retrograde pyelogram revealed a delicate system with identification of the stones seen on imaging.

**Indications**

@AGE@ @SEX@ agreed to undergo the above named procedure after discussion of the alternatives, risks and benefits.

\*\*\*

Informed consent was obtained.

**Procedure**

The patient was taken to the operating room and placed supine on the operating table. Pre-operative antibiotics were administered. Bilateral lower extremity SCDs were placed. After induction of general anesthesia the patient was positioned in dorsal lithotomy, prepped and draped in a sterile fashion. A time-out was performed.

A 14 French flexible cystoscope was passed carefully via urethra into the bladder. The {left/right:311354} ureteral orifice was identified and a Sensor wire was passed retrograde to the level of the kidney and confirmed by fluoroscopy. The flexible scope was off-loaded and the bladder emptied with a straight catheter. \*\*\*An 8-10 coaxial dilator was passed without difficulty and then removed. The MR6A semirigid ureteroscope was passed carefully along the Sensor wire through the urethra and into the distal ureter. The stone was encountered and fragmented with a \*\*\*365-micron holmium YAG laser fiber at laser settings of 0.8 joules and a frequency of 8 Hz. \*\*\*The fragments were basket extracted. At the completion of the procedure, all clinically significant fragments were removed from the ureter and only dust-like fragments remained. The ureteroscope was withdrawn. A 5-French open-ended was passed over the wire and the wire removed. A retrograde pyelogram was performed by slowly injecting 5 mL of 50% Omnipaque contrast via the 5 French catheter with findings described above. An Amplatz super-stiff was placed to the level of the renal pelvis confirmed by fluoroscopy. A 6 x \*\*\* French stent was positioned with the upper end in the upper pole and the lower in the bladder confirmed by fluoroscopy. The bladder was emptied and the procedure was complete. The patient tolerated the procedure well and was stable throughout.

@ATTPROV@ was present in the procedure room the entire duration of the case.

Renalus

**Preprocedure diagnosis**

\*\*\*

**Postprocedure diagnosis**

\*\*\*

**Procedure**

Bilateral renal ultrasound

**Attending surgeon**

@ATTPROV@

**Complications**

None

**Indications**

@AGE@ @SEX@ undergoing a renal ultrasound for the above mentioned indications.

**Procedure**

TECHNIQUE: The patient was taken to the procedure room and renal ultrasound was

performed by assessing gray-scale appearance using the GE 4C convex array transducer at 2-5.5 MHz with the GE LOGIQ

P5 ultrasound system.

The images were obtained starting with the right kidney and then the left kidney with the findings below.  
  
**Findings**

The kidneys are normal in size and echogenicity with size measurements below. Corticomedullary differentiation is preserved.

No evidence of obstruction or hydronephrosis bilaterally.

The RIGHT kidney measures \*\*\*cm x \*\*\*cm x \*\*\*cm.

The LEFT kidney measures \*\*\*cm x \*\*\*cm x \*\*\*cm.

**Plan**

1. \*\*\*

@ATTPROV@ reviewed the obtained and saved images.

Scrotalus

**Preprocedure diagnosis**

\*\*\*

**Postprocedure diagnosis**

\*\*\*

**Procedure**

Scrotal ultrasound

**Attending surgeon**

@ATTPROV@

**Complications**

None

**Indications**

@AGE@ @SEX@ undergoing a scrotal ultrasound for the above mentioned indications.

**Procedure**

TECHNIQUE: Multiple longitudinal and transverse real-time grayscale images of the scrotum and contents were obtained utilizing a high frequency broadband linear transducer (7.5-10 MHz) and color-flow Doppler.  
  
**Findings**

Testicles

The RIGHT testicle is normal in size and appearance.

Dimensions: \*\*\* cm in length, \*\*\* cm AP diameter, \*\*\* cm in transverse diameter Calculated volume: \*\*\* mL (l x w x h x 0.71)

No focal testicular lesion is identified.

Blood flow is normal with color Doppler.

The LEFT testicle is normal in size and appearance

Dimensions: \*\*\* cm in length, \*\*\* cm AP diameter, \*\*\* cm in transverse diameter Calculated volume: \*\*\* mL (l x w x h x 0.71)

No focal testicular lesion is identified.

Blood flow is normal with color Doppler.

Epididymides

There was no evidence of epididymal cysts or masses on the left or right.

**Plan**

1. \*\*\*

@ATTPROV@ reviewed the obtained and saved images.

Stonediet

The patient is at increased risk of developing kidney stones in the future.

**Plan**

1. Dietary recommendations to prevent stone formation

Fluids (Increase)

Please increase your fluid intake

Recommend about 8 glasses of fluid per day.

Please try and keep your urine clear.

If it is dark, this means it is concentrated and you need to drink more fluid.

Citrate (Increase)

Citrate prevents stone formation and is naturally found in urine.

It can be increased by adding lemon juice (two teaspoons per glass) and/or drinking diluted orange juice (50/50 with water).

Salt (Decrease)

Try to limit salt intake.

If you use salt with cooking don't add any additional salt at the table.

Rtntrusbx

**TRUS BIOPSY OF PROSTATE**

**Preoperative diagnosis**

Elevated PSA

**Postoperative diagnosis**

Elevated PSA

**Procedure**

1. Transrectal ultrasound of the prostate

2. Transrectal ultrasound guidance of needle biopsy

3. Prostate biopsy

**Attending Surgeon**

@ENCPROVNMTITLE@

**Anesthesia**

2% lidocaine jelly, intrarectal instillation, 10mL

\*\*\* 1% lidocaine solution, periprostatic injection, 10mL

**Complications**

None

**Specimen**

Prostate biopsy x \*\*\*

**Indications**

Mr. @LNAME@ is a @age@ year old male with an elevated PSA to \*\*\*. After discussing his options, the patient decided to proceed with prostate biopsy. Informed consent was obtained. Possible complications were discussed with the patient during his last visit including, but not limited to, hematuria, hematochezia, prostatitis, urinary tract infection, sepsis, and urinary retention. He {Actions; did/ did not:19250} start the prescribed oral antibiotic regimen.

**Procedure**

The patient was positioned and prepped in a left lateral position with lower extremities flexed. Lidocaine jelly, 2%, was injected per rectum. A digital rectal exam was performed which was {With-without:5700} nodules or induration. The GE E8CS rectal ultrasound probe was slowly introduced into the rectum without difficulty. The prostate and seminal vesicles were inspected systematically using cross and sagittal views with the ultrasound. There {were/not:15343} hypoechoic areas within the prostate. A median lobe {Actions; was/was not:31712} seen. The dimensions of the prostate were measured to be \*\*\*cm X \*\*\*cm X \*\*\*cm, for a calculated volume of \*\*\* mL. Using a true cut 14 Fr biopsy needle, \*\*\* prostate cores were collected. The specific locations were the following: left lateral base, left lateral mid, left lateral apex, left medial base, left medial mid, and left medial apex, right lateral base, right lateral mid, right lateral apex, right medial base, right medial mid, and right medial apex. The rectal ultrasound probe was removed. A DRE was again performed revealing little blood in the rectum. The patient tolerated the procedure well.

**Plan**

1. The patient was instructed to drink plenty of fluids and warned about possible complications and side effects including, but not limited to, blood in the urine, stool and semen as well as bloodstream infection. He was instructed to call the office if there are any issues, especially fevers or flu-like symptoms.

2. Continue antibiotic for a total of 3 days.

3. The patient will return to clinic in approximately 2 weeks for discussion of the pathological report.

@ENCPROVNMTITLE@ was present in the procedure room for the entire procedure.

Shabbladdercanew

I had a lengthy discussion with the patient and explained the natural history of bladder cancer. I explained that bladder cancer is the most common cancer of the urinary tract. diagnosed in approximately 71,000 people each year in the United States, and about 14,000 individuals. More than 90% of bladder cancers in the United States are urothelial tumors. Studies of urothelial bladder cancer have identified multiple risk factors, the most important of which are cigarette smoking and various occupational exposures.

Patients with bladder cancer classically present with painless hematuria, although irritative voiding symptoms (frequency, urgency, dysuria) can be the initial manifestation. In some patients, metastases will cause the initial symptoms.

I explained the normal anatomy of the bladder and informed the patient that most bladder cancer originates from the inner layer (the urothelium). The spectrum of bladder cancer includes non-muscle-invasive (superficial), muscle-invasive, and metastatic disease, each with its own clinical behavior, prognosis, and treatment.

Shabprostatecancernew

CHIEF COMPLAINT

Prostate cancer

HPI

Mr. @LNAME@ is a @AGE@-year-old male with a history of prostate cancer diagnosed on needle biopsy was found to have {Assess; gu bx level:62019055} volume Gleason {NUMBERS; GU:62019056} disease on needle biopsy for an {Results; gu:62019057}. With {NUMBERS; GU:62019056} out of {NUMBERS; GU:62019056} cores positive for cancer, He was referred for discussion of treatment options.

PAST MEDICAL HISTORY

@PMH@

PAST SURGICAL HISTORY

@PSH@

ALLERGIES

@ALLERGY@

MEDICATIONS

@CMEDLIST@

SOCIAL HISTORY

@SOC@

**Review of Systems**

1. IPSS: SHIM: KPS: ECOG
2. Constitutional: Negative for fever, chills, weight loss, weight gain and malaise/fatigue.
3. Skin: Negative for rash.
4. Eyes: Negative for blurred vision and eye redness.
5. Cardiovascular: Negative for chest pain, dyspnea on exertion, palpitations, orthopnea, claudication and leg swelling.
6. Respiratory: Negative for cough, hemoptysis and sputum production. Is not experiencing shortness of breath or wheezing.
7. Gastrointestinal: Negative for heartburn, nausea, abdominal pain, diarrhea, constipation, blood in stool and melena.
8. Breast: Negative for swelling and tenderness.
9. Genitourinary: Negative for bladder incontinence, dysuria, urgency, frequency, hematuria, flank pain, hesitancy, penile discharge, genital lesions, testicular pain, testicular mass.
10. Musculoskeletal: Negative for back pain and joint pain.
11. Neurological: Negative for dizziness, tingling, focal weakness and headaches.
12. Lymph/Heme: Negative for easily bruises / bleeds and lymph node swelling.

**Physical Exam**

1. @VS@
2. Constitutional: He is oriented and well-developed, well-nourished, and in no distress.
3. HENT:
4. Head: Normocephalic.
5. Mouth/Throat: Oropharynx is clear and moist.
6. Eyes: Conjunctivae are normal.
7. Cardiovascular: Normal rate, regular rhythm and normal heart sounds.
8. No murmur heard.
9. Pulmonary/Chest: He has no wheezes. He has no rales.
10. Abdominal: Soft. He exhibits no distension and no mass. There is no organomegaly. No tenderness. He has no rebound, no guarding and no CVA tenderness. No hernia.   
    Genitourinary: He exhibits no abnormal testicular mass and no testicular tenderness. No discharge found.
11. Rectal exam shows no external hemorrhoid, no internal hemorrhoid and no mass. Prostate is not tender.Lymphadenopathy:   
     He has no cervical adenopathy.   
     He has no axillary adenopathy.   
     Right: No inguinal adenopathy present.   
     Left: No inguinal adenopathy present.
12. Neurological: He is alert and oriented.

**Diagnostic Tests**

@THISVISIT@

@BRIEFLAB(CREATININE,CREATININES)@

@BRIEFLAB(PSA:\*)@

ASSESSMENT AND PLAN

Prostate cancer.

He was counseled extensively on the nature of his cancer using the Memorial Sloan Kettering Cancer Center prostate cancer nomogram, the patient have a ({Numbers; 5-10:32597} chance of having organ confined disease and ({Numbers; 5-10:32597} risk of having lymph node involvement, the 5 and 10 years biochemical free survival after radical prostatectomy is ({Numbers; 5-10:32597} and ({Numbers; 5-10:32597} respectively. And the five year recurrence free survival after brachytherapy is ({Numbers; 5-10:32597}. And the 5 year rate of development of metastatic disease after external bean radiation therapy is ({Numbers; 5-10:32597}.treatment options including active surveillance, surgical, and radiation-based options. We also discussed cryoablation and HIFU ablation. He was given detailed information regarding the short term and long term advantages and disadvantages of each treatment option. Including detailed discussion of the urinary, sexual and bowel complications. We discussed robotic surgery in particular with discussion of the expected perioperative course, risks, complications, and potential side effects. We also discussed the concept of nerve sparing and the balance between cancer control and erectile function. All of his questions were answered. He has decided {Plan; gu robotic surg:62019058} .

Spent more than 60 minutes with the patient between evaluation and discussion with more than half time in discussing the different treatment options.

Shabgrosshematuria

I had detailed discussion with the patient regarding her symptom of gross hematuria. I explained that the color change does not necessarily reflect the degree of blood loss, since as little as 1 mL of blood in a liter of urine may induce a visible color change. In addition, the intermittent excretion of red to brown urine can be seen in a variety of conditions other than bleeding into the urinary tract.

The causes of gross hematuria vary with age with the most common being inflammation or infection of the prostate or bladder, stones, trauma and, in older patients, a kidney or urinary tract malignancy or benign prostatic hyperplasia in males. Other rare conditions can also cause gross hematuria such as hematologic diseases or anatomical anomalies. I explained that hematuria can be from renal or extrarenal bleeding, and the workup depend on the history, physical examination and the patient's age. I recommended further evaluation including urine tests, imaging studies such as CT urogram or IVP and cystoscopic evaluation.

I described in details what a cystoscopic examination means and how it is performed and the possible side effects and complications. I told the patient that cystoscopy is a test that allows me to look at the inside of the bladder and the urethra using a thin, instrument called a cystoscope. The procedure is done under sterile condition, we may need to administer one dose of antibiotics prior to the procedure. A local anesthetic gel (local anesthesia) will be administered into the urethra. 20 minutes later the cystoscope is inserted into the urethra and slowly advanced into the bladder. Tiny surgical instruments can be inserted through the cystoscope that allow your doctor to remove samples of tissue (biopsy) or samples of urine. I informed the patient that most people report that this test is not nearly as uncomfortable as they had expected. And that cystoscopy is generally a very safe test. There is no risk of loss of sexual function. The most common side effect is a temporary difficulty to urinate. Bleeding sometimes occurs, but it usually stops on its own. In rare cases a mild infection in the urinary tract may develop after cystoscopy. It is even less likely that the infection can spread through the body, and in very rare circumstances, usually with seriously ill people, the infection can be life-threatening. Another rare complication is injury of the urethra or bladder by one of the instruments, which may requires surgery to repair.

Stopbang

STOP Risk Assessment

1. Do you Snore? {Responses; yes no:18458}

2. Are you frequently tired during the day? {Responses; yes no:18458}

3. Have you been observed gasping or choking while asleep? {Responses; yes no:18458}

4. Do you have high blood Pressure? {Responses; yes no:18458}

5. Have you been diagnosed with OSA?{Responses; yes no:18458}

STOP-Bang Questionnaire

1. Do you Snore? {Responses; yes no:18458}

2. Are you frequently tired during the day? {Responses; yes no:18458}

3. Have you been observed gasping or choking while asleep? {Responses; yes no:18458}

4. Do you have high blood Pressure? {Responses; yes no:18458}

5. BMI - greater than 35kg/m2? {Responses; yes no:18458}

6. Age - over 50 years old? {Responses; yes no:18458}

7. Neck Circumference - greater tahn 40 cm? {Responses; yes no:18458}

8. Gender - Male? {Responses; yes no:18458}

tele

Patient verbally consents to the submission of a Telephone Visit; patient is aware of the risks, benefits, and possible coinsure/ copay cost.

Call Duration:

Trimixfuq

Trimix VI

Dose:

Erectile Rigidity:

Duration:

Frequency:

Misses:

ICIREportsheet

**ICI Report Sheet – Dr. Jenkins**

MyChart or 614-293-8155

Leave the following information, via MyChart or when calling and if there is no answer

1. Your name and date of birth
2. Name of medication – Trimix 6 / BiMix 3 / SuperTrimix 2
3. How much medication \_\_\_\_\_\_\_ units
4. Quality of erection \_\_\_\_/10

0 = no erection at all

1 =

2 =

3 =

4 =

5 =

6 = just enough for vaginal penetration

7 = just enough for anal penetration

8 =

9 =

10 = rock hard

1. How long for penetration hardness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ minutes
2. Your phone number to return your phone call

Glursmale

OPERATIVE REPORT DATE: @TODAYDATE@

NAME: @NAME@

ATTENDING PHYSICIAN: Gregory Lowe, MD   
  
  
PREOPERATIVE DIAGNOSIS  
\*\*\*  
  
POSTOPERATIVE DIAGNOSIS  
\*\*\*  
  
PROCEDURE  
1. Cystoscopy with {LEFT/RIGHT/BILATERAL:20202} retrograde pyelography, ureteroscopy, laser lithotripsy ofstones and {LEFT/RIGHT/BILATERAL:20202} stent placement.

2. Fluoroscopy with interpretation of images intraoperatively.  
  
SURGEON  
Gregory Lowe, MD

ASSISTANTS

\*\*\*  
  
ANESTHESIA  
\*\*\*  
  
ESTIMATED BLOOD LOSS  
{None:18700}  
  
COMPLICATIONS  
{None:18700}

INDICATIONS

Mr. @NAME@ is a @AGE@ who presented with \*\*\*. A discussion was undertaken regarding the possible options for treatment and he wished to proceed with ureteroscopy and laser lithotripsy. Informed consent was obtained.

PROCEDURE

Mr. @NAME@ was properly identified and brought to the procedure room. He \*\*\* sequential compression devices placed and received peri-operative antibiotics. After the smooth induction of anesthesia, he was moved into the dorsal lithotomy position. His lower abdomen, genitalia and perineum were prepped and draped in sterile fashion. We began the procedure by performing a \*\*\* cystoscopy and easily guiding the cystoscope along his urethra and into the bladder. The bladder was examined and no tumors or stones were noted. The {RIGHT/LEFT:21423} ureteral orifice was identified and cannulated with a sensor guide wire. The cystoscope was then removed and a 5-Fr open ended catheter advanced over the wire. The wire was removed and a retrograde pyelogram performed. This revealed \*\*\* tumors or filling defects. The stones \*\*\* visualized on imaging prior to the retrograde or with fluoroscopy. The calyces \*\*\* blunted. The sensor wire was replaced through the 5-Fr catheter and the catheter removed. An 8-10 coaxial dilator was used to dilate the distal ureter under fluoro and to insert a super stiff wire along the sensor wire. The 10 sheath was removed and the bladder drained with a catheter. The super stiff wire was then used to pass a \*\*\* under fluoroscopic guidance. Once this was in place, a flexible ureteroscope was used to examine the renal pelvis and calyces. A stone was identified \*\*\*. Laser lithotripsy was used with settings of \*\*\* J and \*\*\* Hz to break the stone into \*\*\* pieces. Once the fragments were \*\*\*, we re-examined each calyx to ensure no other stones were missed. A stone {WAS:18477} retrieved with a basket for analysis. The ureteroscope \*\*\* {WAS:18477} removed under direct vision without difficulty. A \*\*\* stent {WAS:18477} placed using fluoroscopic guidance. Over the retained sensor wire the 5-Fr open ended catheter was placed and the renal pelvis injected for identification for stent placement. At the end the stent curl was noted in both the renal pelvis and the bladder.

\*\*\*

At the end of the case, all instrument, needle and sponge counts were correct. I, Dr. Lowe, was present in the room for the entire case.

PLAN

\*\*\*

Glturbt

**Preoperative diagnosis**

\*\*\*

**Postoperative diagnosis**

Same as above

**Procedure performed**

1. Exam under anesthesia

2. Rigid cystoscopy

3. {Right/left:16020} retrograde pyelogram

4. Transurethral resection of bladder tumor, <2cm, 2-5cm, >5cm\*\*\*

5. Fluoroscopy time < 1 hour

**Attending surgeon**

@ENCPROVNMTITLE@

**Anesthesia**

General

**EBL**

10 mL

**Complications**

None

**Specimen**

Bladder tumor for pathology

**Findings**

Exam under anesthesia revealed \*\*\*

Cystoscopy revealed a bladder mass \*\*\*.

Left retrograde pyelogram revealed \*\*\*

Right retrograde pyelogram revealed \*\*\*

**Indications**

@AGE@ @SEX@ agreed to undergo the above named procedure after discussion of the alternatives, risks and benefits. Informed consent was obtained.

**Procedure**

The patient was taken to the operating room and placed supine on the operating table. Pre-operative antibiotics were administered. Bilateral lower extremity SCDs were placed. After induction of general anesthesia the patient was positioned in dorsal lithotomy. A time-out was performed. An exam under anesthesia was performed with the above described findings. The patient was prepped and draped in a sterile fashion.

A 21 French rigid cystoscope was introduced into the bladder under direct vision. The bladder was inspected with both the 30 and 70 degree lenses. A 27-1/2 French continuous flow resectoscope was introduced into the bladder. Using a working element, the described mass was resected in its entirety. Hemostasis was confirmed. There was negligible blood loss. The patient tolerated the procedure well, was awakened, extubated and transferred to the recovery room in stable condition.

@ENCPROVNMTITLE@ was present in the procedure room for the entire procedure.

Stentor

PREPROCEDURE DIAGNOSIS:

1. \*\*\*

POSTPROCEDURE DIAGNOSIS:

Same

PROCEDURE:

1. Cystoscopy with {LEFT/RIGHT/BILATERAL:20202} retrograde pyelogram.

2. {LEFT/RIGHT/BILATERAL:20202} ureteral stent placement size \*\*\* cm.

SURGEONS.: Gregory J Lowe, M.D.

ASSISTANT: \*\*\*, M.D.

ANESTHESIA:

\*\*\*

SPECIMENS: None.

ESTIMATED BLOOD LOSS: None.

COMPLICATIONS: None.

INDICATIONS: @NAME@ is a @AGE@ \*\*\*man who was referred for a ureteral stent placement as \*\*\*. A discussion was undertaken with the patient in regards to potential treatment options and wished to proceed with a ureteral stent.

Informed consent was obtained.

PROCEDURE: @NAME@ was properly identified and brought to the procedure room. {He/she (caps):30048} underwent the smooth induction of anesthesia and had an LMA placed. {He/she (caps):30048} was placed in dorsal lithotomy on the table and a time-out was performed. SCDs were in place. {He/she (caps):30048} received \*\*\* as a perioperative antibiotic. Initially she was prepped over the genitalia with Hibiclens and draped in standard sterile fashion. We began by using a \*\*\*21-French rigid cystoscope and easily guiding this into the bladder. Upon inspection of bladder, \*\*\* tumors, stones or trabeculation was noted. There were \*\*\* patches of erythema. The \*\*\* ureteral orifice was cannulated and a retrograde pyelogram performed. This revealed \*\*\* filling defects and a delicate collecting system. There was prompt drainage from the ureteral orifice. The \*\*\* ureteral orifice was then able to be identified and cannulated with a sensor wire. This was advanced up to the kidney under fluoroscopic guidance. The cystoscope

was removed and over the sensor wire a 5-French open-ended catheter placed. Using a 5-French open-ended catheter, a retrograde

pyelogram was performed. There did \*\*\* appear to be a proximal ureteral filling defect. The calyces were \*\*\* dilated. {He/she (caps):30048} did have \*\*\*. The sensor wire was then placed through the 5-French open-ended catheter and the 5-French open-ended catheter removed. Over the superstiff wire a \*\*\* cm ureteral stent was placed without difficulty. A good proximal and distal curl was confirmed using fluoroscopy. Once this was completed, the procedure was terminated.

The patient tolerated the procedure well. At the end, all sponge and instrument counts were correct. The patient was subsequently taken to the recovery unit without incident.

PLAN: Follow up with \*\*\*

I, Dr. Lowe, was present for the entire operation.

Stentclinic

PREPROCEDURE DIAGNOSIS:

1. \*\*\*

POSTPROCEDURE DIAGNOSIS:

1. \*\*\*

PROCEDURE:

1. Cystoscopy with \*\*\* retrograde pyelogram.

2. \*\*\* ureteral stent placement size \*\*\* cm.

SURGEONS.: Gregory J Lowe, M.D.

ASSISTANT: \*\*\*

ANESTHESIA:

Administered by the primary surgeon utilizing fentanyl and Versed. All the patient's vital signs including blood pressure, pulse, and pulse oximetry were monitored throughout the case and noted to remain stable.

SPECIMENS: None.

ESTIMATED BLOOD LOSS: None.

COMPLICATIONS: None.

INDICATIONS: @NAME@ is a @AGE@ {MAN/WOMAN:20048} who was referred for

a ureteral stent placement as \*\*\*.

A discussion was undertaken with the patient in regards to

potential treatment options and wished to proceed with a ureteral stent.

Informed consent was obtained.

PROCEDURE: @NAME@ was properly identified and brought to the

procedure room. {He/she (caps):30048} was laid supine on the table and a time-out was

performed. Once this was completed, we began with initiation of

moderate conscious sedation using fentanyl and Versed. Prior to coming to the operating room, the patient had been given \*\*\* mg of oral ciprofloxacin. The patient was noted to start to become drowsy and thus the procedure began. Initially{HE/SHE (NO CAPS):19870} was prepped over the genitalia with Hibiclens and draped in standard sterile fashion. We began by using a 14-French flexible cystoscope and easily

guiding this into the bladder. Upon inspection of bladder, \*\*\* tumors,

stones or trabeculation was noted. There were \*\*\* patches of erythema.

The \*\*\* ureteral orifice was able to be identified and cannulated with a sensor wire. This was advanced up to the kidney under fluoroscopic guidance. The cystoscope

was removed and over the sensor wire a 5-French open-ended catheter

placed. The vital signs including blood pressure, pulse oximetry and heart rate were normal and stable throughout. Using a 5-French open-ended catheter, a retrograde

pyelogram was performed. Care was taken to not over distend this region.

However, no tumors or filling defects were identified. The exact point

of obstruction was unable to be determined given the lack of complete

filling. The superstiff wire was then placed through the 5-French open-

ended catheter and the 5-French open-ended catheter removed. Over the

superstiff wire a \*\*\* cm ureteral stent was placed without

difficulty. A good proximal and distal curl was confirmed using

fluoroscopy. Once this was completed, the procedure was terminated.

The patient tolerated the procedure well. At the end, all sponge and

instrument counts were correct. The patient was subsequently taken to

the recovery unit without incident.

PLAN: We will plan to have \*\*\* return in 3 months' time for a

repeat stent exchange.

I, Dr. Lowe, was present for the entire operation.

Stentchangeclinic

PREPROCEDURE DIAGNOSIS:

1. \*\*\*

POSTPROCEDURE DIAGNOSIS:

1. same

PROCEDURE:

1. Cystoscopy with \*\*\* retrograde pyelogram.

2. \*\*\* ureteral stent placement size \*\*\* cm.

3. Removal of \*\*\* indwelling ureteral stent.

SURGEONS.: Gregory J Lowe, M.D.

ASSISTANT: \*\*\*, M.D.

ANESTHESIA:

Administered by the primary surgeon utilizing fentanyl and Versed. All the patient's vital signs including blood pressure, pulse, and pulse oximetry were monitored throughout the case and noted to remain stable.

SPECIMENS: None.

ESTIMATED BLOOD LOSS: None.

COMPLICATIONS: None.

INDICATIONS: @NAME@ is a @AGE@ y.o. {MAN/WOMAN:20048} who was referred for a ureteral stent placement as \*\*\*. He has had an indwelling stent and presents for stent exchange.

A discussion was undertaken with the patient in regards to potential treatment options and wished to proceed with stent exchange.

Informed consent was obtained.

PROCEDURE: @NAME@ was properly identified and brought to the procedure room. {He/she (caps):30048} was laid supine on the table and a time-out was performed. Once this was completed, we began with initiation of moderate conscious sedation using fentanyl and Versed. Prior to coming to the operating room, the patient had been given \*\*\* mg of oral ciprofloxacin. The patient was noted to start to become drowsy and thus the procedure began. Initially {HE/SHE (NO CAPS):19870} was prepped over the genitalia with Hibiclens and draped in standard sterile fashion. We began by using a 14-French flexible cystoscope and easily guiding this into the bladder. Upon inspection of bladder, \*\*\* tumors, stones or trabeculation was noted. There were \*\*\* patches of erythema. The existing ureteral stent was able to be identified and grasped with a stent grasper. It was removed with the cystoscope and then cannulated with a sensor wire. This was advanced up to the kidney under fluoroscopic guidance. The old stent was removed leaving the wire in place. Over the sensor wire a 5-French open-ended catheter placed. The vital signs including blood pressure, pulse oximetry and heart rate were normal and stable throughout. Using a 5-French open-ended catheter, a retrograde pyelogram was performed. Care was taken to not over distend this region. However, no tumors or filling defects were identified. The exact point of obstruction was unable to be determined given the lack of complete filling. The superstiff wire was then placed through the 5-French open-ended catheter and the 5-French open-ended catheter removed. Over the superstiff wire a \*\*\* cm ureteral stent was placed without difficulty. A good proximal and distal curl was confirmed using fluoroscopy. Once this was completed, the procedure was terminated. The patient tolerated the procedure well. At the end, all sponge and instrument counts were correct. The patient was subsequently taken to

the recovery unit without incident.

PLAN: We will plan to have \*\*\* return in 3 months' time for a

repeat stent exchange.

I, Dr. Lowe, was present for the entire operation.

Clinicsptube

PREPROCEDURE DIAGNOSIS:

1. \*\*\*

POSTPROCEDURE DIAGNOSIS:

1. same

PROCEDURE:

1. Cystoscopy.

2. Suprapubic catheter insertion via puncture.

SURGEONS.: Gregory J Lowe, M.D.

ASSISTANT: \*\*\*, M.D.

ANESTHESIA:

Administered by the primary surgeon utilizing fentanyl and Versed. All the patient's vital signs including blood pressure, pulse, and pulse oximetry were monitored throughout the case and noted to remain stable.

SPECIMENS: None.

ESTIMATED BLOOD LOSS: None.

COMPLICATIONS: None.

INDICATIONS: @NAME@ is a @AGE@ \*\*\* who was referred for

a \*\*\*.

A discussion was undertaken with the patient in regards to

potential treatment options and wished to proceed with another SP tube trial prior to more invasive surgery.

PROCEDURE: @NAME@ was properly identified and brought to the procedure room. She was laid supine on the table and a time-out was performed. Once this was completed, we began with initiation of moderate conscious sedation using fentanyl and Versed. Prior to coming to the operating room, the patient had been given 80 mg of gentamycin. The patient was noted to start to become drowsy and thus the procedure began. Initiallyshe was prepped over the genitalia and lower abdomen with Hibiclens and draped in standard sterile fashion. We began by using a 14-French flexible cystoscope and easily guiding this into the bladder. Upon inspection of bladder, no tumors,

stones or trabeculation was noted. There were no patches of erythema. There were a few diverticula and moderate debris. We filled the bladder with saline and palpated through the anterior lower abdomen to find a placement for the SP tube. This was visualized to be along the anterior dome of the bladder. Local anesthesia was infiltrated into the subcutaneous tissue. A small 1 cm incision was created in the skin. Using the Chiou SP tube set, the puncture needle was guided into the bladder without difficulty. A wire was placed through this needle into the bladder. The needle was removed and serial dilation performed from 8 to 10 Fr, followed by placement of the catheter introducer sheath. Once in place and confirmed visually with the cystoscope, the wire was removed and an 18 Fr Council tip catheter inserted. This balloon was filled with 15 mL of saline. The sheath was then removed. The catheter was sewn to the skin with a 3-0 Nylon suture.

Once this was completed, the procedure was terminated. The patient tolerated the procedure well. At the end, all sponge and instrument counts were correct. The patient was subsequently taken to the recovery unit without incident.

PLAN: We will plan to have \*\*\* return in 4 weeks for SP tube exchange in the office.

I, Dr. Lowe, was present for the entire operation.

Glsuprpubiccath

PREPROCEDURE DIAGNOSIS:

1. \*\*\*

POSTPROCEDURE DIAGNOSIS:

1. same

PROCEDURE:

1. Cystoscopy.

2. Suprapubic catheter insertion via puncture.

SURGEONS.: Gregory J Lowe, M.D.

ASSISTANT: \*\*\*, M.D., \*\*\*, M.D.

ANESTHESIA: LMA

SPECIMENS: None.

ESTIMATED BLOOD LOSS: None.

COMPLICATIONS: None.

INDICATIONS: \*\*\* is a \*\* y.o. male who was referred for urinary retention. A discussion was undertaken with the patient in regards to potential treatment options and wished to proceed with another SP tube trial .

PROCEDURE: \*\*\* was properly identified and brought to the procedure room. He was laid supine on the table and a time-out was performed. Perioperative antibiotics were administered and he had SCD in place. \*\*\*He underwent smooth induction of general anesthesia. Initially he was prepped over the genitalia and lower abdomen with Hibiclens and draped in standard sterile fashion. We began by using a 14-French flexible cystoscope and easily guiding this into the bladder. Upon inspection of bladder, no tumors, stones or trabeculation was noted. There were no patches of erythema. The prostate did appear non-occlusive. There were a few diverticula and moderate debris. We filled the bladder with saline and palpated through the anterior lower abdomen to find a placement for the SP tube. This was visualized to be along the anterior dome of the bladder. A small 1 cm incision was created in the skin. Using the Lawrence SupraFoley catheter introducer, the puncture needle was guided into the bladder without difficulty. Once in place and confirmed visually with the cystoscope, the introducer was removed and a 16 Fr Council tip catheter inserted. This balloon was filled with 10 mL of saline. The sheath was then removed. The catheter was sewn to the skin with a 3-0 Nylon suture.

Once this was completed, the procedure was terminated. The patient tolerated the procedure well.

At the end, all sponge and instrument counts were correct. The patient was subsequently taken to the recovery unit without incident.

PLAN: We will plan to have \*\*\* return in 4 weeks for SP tube exchange in the office.

I, Dr. Lowe, was present for the entire operation.

Glclinicpesatesatese

Operative Report

LOCATION OF PROCEDURE: Clinic procedure room.

PREOPERATIVE DIAGNOSES:

1. Azoospermia

POSTOPERATIVE DIAGNOSES:

1. Same

SURGEON: Gregory J Lowe, MD.

ASSISTANT: \*\*\*, MD.

ANESTHESIA: \*\*\*Local 2% lidocaine cord block bilaterally and locally applied to skin.

SPECIMENS:

1. \*\*\*

2. Remaining samples sent with \*\*\*.

PROCEDURE:

Bilateral testicular sperm extraction and testes biopsy.

Bilateral percutaneous sperm aspiration from epididymis.

COMPLICATIONS: None.

DRAINS: None.

INDICATIONS: Mr. \*\*\* is a \*\*\*-year-old gentleman with a history of \*\*\*. He does desire fertility. A discussion was undertaken regarding

options for sperm harvest and the use of in-vitro fertilization. Informed consent was obtained.

PROCEDURE: Mr. \*\*\* was properly identified and brought to the procedure room. He was laid supine on the table. He previously had been given \*\*\*Xanax and Percocet as well. After this, his

genitalia were prepped with \*\*\* and he was draped in standard sterile fashion. A time-out was performed.

An embryologist, \*\*\* was present for the procedure to identify

sperm. Initially a bilateral spermatic cord block was performed with 2% plain lidocaine. A local skin block was also performed. The anesthetic took effect and then a 25 gauge butterfly needle with human tubular fluid was used to aspirate directly from the left epididymis. This fluid aspirated was passed to the embryologist. The same was then performed over the right side. A third aspiration was performed at the location of the right epididymal head and superior testis. All the fluid remained with the embryologist. We began by making a 1-1/2 cm incision along the scrotal raphe

in the midline. This was carried down through the skin and onto the

left tunica vaginalis. The left tunica vaginalis was opened and the

tunic albuginea of the testicle exposed. A 5-0 Prolene suture was pre-

placed and a horizontal incision created in the tunica albuginea.

Through this incision with gentle pressure on the testicle, seminiferous

tubules were extruded. These tubules were excised and sent for

pathological evaluation as well as the majority being passed off the

table for sperm extraction.

On microscopic bedside examination it was noted that there were sperm

seen; however most were nonmotile. Making sure that there was good

hemostasis and the tunic albuginea was closed with a 5-0 Prolene pre-

placed Prolene suture.

We then closed the tunica vaginalis with a 3-0 chromic suture.

\*\*\*At this point, we turned our attention to the opposite side and did the

exact same procedure. Again a 5-0 Prolene suture was pre-placed and the tunic albuginea opened. The seminiferous tubules were exposed and placed in a sterile

petri dish and passed off the table. Again sperm were seen on the right

evaluation and a few were noted to be twitching. Once this had been completed, we closed the tunica albuginea on the right side, followed by closure of the tunica vaginalis on the right.

We ensured that there was good hemostasis and began our skin closure.

The skin was closed with a 3-0 chromic suture in a horizontal mattress

fashion.

We have requested that the patient have ice supplied in the recovery

unit to minimize swelling.

At the end of the procedure, all instrument, needle, and sponge counts were correct.

I, Dr. Lowe, was present and scrubbed for the entire procedure.

Glscrotalpain

We discussed treatments to minimize testicular/scrotal discomfort today. These include daily sitz bath, NSAIDs, scrotal support with tighter underwear and pelvic floor relaxation. In addition, I recommended he use neurontin 100 mg TID for the next month to attempt to settle any nerve discomfort which may be present.

2. Follow up in 4 weeks for reevaluation. If not improved at that time, will consider spermatic cord block with marcaine to assess if the discomfort appears to originate in the testicle.

Glscrotalabscess

LOCATION OF PROCEDURE: \*\*\*

PREOPERATIVE DIAGNOSIS:

1. Scrotal abscess

POSTOPERATIVE DIAGNOSIS: Same

PROCEDURE: \*\*\*

SURGEON: Dr. Gregory Lowe.

ASSISTANT: \*\*\*

ANESTHESIA: \*\*\*

ESTIMATED BLOOD LOSS: \*\*\* mL.

COMPLICATIONS: \*\*\*

DRAINS: \*\*\*

SPECIMENS: \*\*\*

INDICATIONS: @NAME@ is a @AGE@ gentleman who has noted \*\*\*. He {HAS HAS NOT:19958} had an ultrasound that was consistent with a scrotal abscess. We discussed incision and drainage of this abscess and he was ready to proceed. Informed consent was obtained.

DESCRIPTION OF PROCEDURE: @NAME@ was properly identified and brought to

the procedure room. He was laid supine on the table, and sequential

compression devices were placed. He was given perioperative antibiotics

and underwent the smooth induction of anesthesia. If needed, scrotal shaving was performed followed by prepping with \*\*\*. He was then draped in standard sterile fashion. A timeout was performed and the procedure begun.

A \*\*\*-cm scrotal incision was created \*\*\*. A culture of the abscess fluid {WAS:18477} collected. The incision was carried down to evacuate the abscess fluid and blunt dissection utilized to break up any loculation. Irrigation was used to wash the wound with sterile saline. The wound appeared to be healthy and packing was performed with \*\*\*.

At the end of the procedure all instrument, needle and sponge counts were correct.

I, Dr. Lowe, was present in the room for the entire procedure.

Plan:

@NAME@ will be kept in the hospital until comfortable and tolerating packing.

Glrug

Pre-operative Dx:

Post-operative Dx:

Procedure: retrograde urethrogram with injection of radiographic contrast

Attending: Dr. Lowe

Resident: \*\*\*

Findings: \*\*\*

Indications:

@NAME@ is a @AGE@ \*\*\*male with history of \*\*\*. He presents today for a retrograde urethrogram. he was informed of the possible complications including bleeding and infection. Informed consent was obtained.

Procedure:

@NAME@ was brought back to the procedure suite and laid in a modified left lateral decubitus position. Scout films were obtained of the pelvis to confirm appropriate positioning. A \*\*\* was obtained that had been filled with iodonated contrast. The tip was lubricated and the urethral meatus was cannulated. Under live fluoroscopy, contrast was injected and images of the urethra were obtained. An approximately \*\* cm stricture in the \*\* urethra. The stricture did \*\* appear to be completely obstructing. After obtaining the images, the syringe was removed from the urethra.

Disposition: The patient tolerated the procedure well and was discharged home in stable condition.

Glorstent

**Preoperative diagnosis**

{LEFT/RIGHT CAP:19321} hydronephrosis

**Postoperative diagnosis**

{LEFT/RIGHT CAP:19321} hydronephrosis

**Procedure performed**

1. Flexible cystoscopy

2. {LEFT/RIGHT CAP:19321} retrograde pyelogram

3. {LEFT/RIGHT CAP:19321} ureteral stent exchange, \*\*\* x \*\*\* French

4. Fluoroscopy time < 1 hour

**Attending surgeon**

@ATTPROV@

**Anesthesia**

General

**Complications**

None

**Findings**

Cystoscopy revealed no tumors, stones or other mucosal abnormalities.

Retrograde pyelogram revealed a \*\*\* dilated system with \*\*\* filling defects.

**Indications**

@AGE@ @SEX@ agreed to undergo the above named procedure after discussion of the alternatives, risks and benefits. Informed consent was obtained.

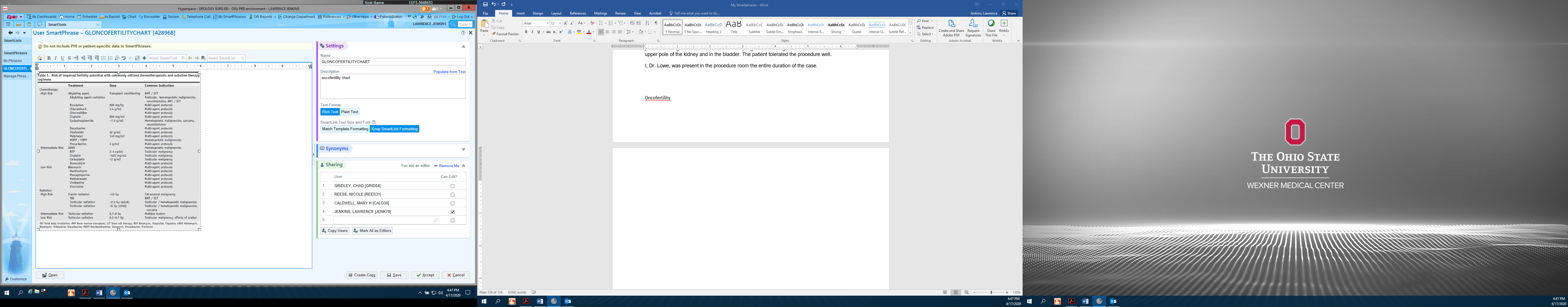
**Procedure**

The patient was taken to the operating room and placed supine on the operating table. Pre-operative antibiotics were administered. Bilateral lower extremity SCDs were placed. After induction of general anesthesia the patient was positioned in dorsal lithotomy, prepped and draped in a sterile fashion. A time-out was performed.

A 14 French flexible cystoscope was passed carefully via urethra into the bladder. A Sensor wire was passed retrograde through the {left/right:311354} ureteral orifice. A 5-French open-ended catheter was passed over the wire. A retrograde pyelogram was performed by slowly injecting \*\*\*mL of Omnipaque contrast via the 5 French catheter with findings described above. A superstiff wire was then placed into the upper pole and a 6 x \*\*\* French ureteral stent was placed in retrograde fashion under fluoroscopic guidance with good coil confirmed to be in the upper pole of the kidney and in the bladder. The patient tolerated the procedure well.

I, Dr. Lowe, was present in the procedure room the entire duration of the case.

Oncofertility



Instillation

**Today the patient was instilled with \*\*\* via catheter in clinic under sterile conditions using straight catheter. 14 French straight catheter placed in standard fashion with no difficulty. Patient instructed to void in approximately 30 minutes**

Greenlightopnote

Patient's name and date of treatment

\*\*\* anesthesia for the procedure was jointly selected by

the patient and his anesthesiologist. The patient was taken to the operating room, placed in the dorsal lithotomy position and prepped and draped in the usual sterile manner.

The prostate size was estimated to be g during previous examination.

A \_\_\_\_ Fr continuous-flow cystoscope was connected to saline solution irrigation and inserted into the bladder without difficulty in the usual fashion. A preliminary cystoscopic

examination was performed during which the ureteral orifices, bladder neck and

verumontanum were identified.

The GreenLight XPS™ laser was set at \*\*\* watts. The GreenLight XPS MoXy™ laser fiber was introduced through the working channel of the cystoscope. The median lobe was identified and it was vaporized down to capsular fibers. The bladder neck was then vaporized as far laterally as possible to open up the prostatic urethra. The median lobe was vaporized from the bladder neck to the verumontanum. The left and right lateral lobes were vaporized from the bladder neck to the verumontanum. Vaporization was continued until the capsular fibers were visualized or until the lateral lobes were adequately vaporized. The proximal adenoma was vaporized first, then the scope was withdrawn to the verumontanum and the most distal adenoma was vaporized, always ensuring that the verumontanum was well isolated. By serially vaporizing the obstructing tissue, a wide open prostatic urethral channel was created. A total of joules were used during the procedure. During the procedure, any bleeding vessels were effectively controlled. At the end of the procedure, the bladder neck, ureteral orifices, and verumontanum were again inspected, and found to be intact, and without evidence of incidental laser beam damage. The bladder was filled with saline solution irrigation, and the continuous flow cystoscope was removed. External pressure was applied to the dome of the bladder to ascertain the quality of the urinary stream. A strong urine flow was achieved, with minimal evidence of bleeding.

A \_\_\_\_\_\_\_\_\_\_\_\_\_ Fr (5cc) Foley catheter to straight drainage was inserted.

The patient was transferred to the PACU (Perianesthesia Care Unit) in good condition.

Frenulumrelease

LOCATION OF PROCEDURE: \*\*\*

PREOPERATIVE DIAGNOSIS:

1. Short tethered penile frenulum

POSTOPERATIVE DIAGNOSIS: Same

PROCEDURE: Release of short frenulum

SURGEON: Dr. Gregory Lowe.

ASSISTANT: Dr. \*\*\*

ANESTHESIA: 2% lidocaine for dorsal penile nerve block and local anesthesia

ESTIMATED BLOOD LOSS: \*\*\* mL.

COMPLICATIONS: \*\*\*

SPECIMENS: none

INDICATIONS: \*\*\* is a \*\*\* y.o. gentleman who has noted to have a short and tethering frenulum. This causes \*\*\*. Informed consent was obtained.

DESCRIPTION OF PROCEDURE: @NAME@ was properly identified and brought to the procedure room. He was laid supine on the table. He was preped with \*\*\*. He was then draped in standard sterile fashion. A timeout was performed and the procedure begun.

Local anesthesia was performed with 2% lidocaine. This was injected initially along the dorsal nerves bilaterally and then ventral proximal to the frenulum.

We then used the \*\*\* surgical clips to clip the frenulum along the glans. A second clip was placed at the further extent of the frenulum. We cut between these clips and the frenulum began to release. \*\*\*A second row of clips was performed for complete frenular release.

At the end of the procedure all instrument, needle and sponge counts were correct.

I, Dr. Lowe, was present in the room for the entire procedure.

Plan:

Follow up in 2-3 weeks to assess healing.

Fillandvoid

Today the patient was filled with \*\*\* of saline and the old catheter removed. He was then allowed to void. He voided approximately \*\*\* mL and PVR was \*\*\* mL.

Ljdenervation

**PREOPERATIVE DIAGNOSIS:** Chronic orchalgia

**POSTOPERATIVE DIAGNOSIS:** Chronic orchalgia

**PROCEDURE:** Neuroplasty, major peripheral nerve, arm or leg, open, other (64708); Internal neurolysis, requiring use of operating microscope (64727); Ultrasonic guidance, intraoperative (76998-26); Excision of varicocele or ligation of spermatic veins for varicocele (55530)

**SIDE:** Left\*\*\*

**SURGEON:** Lawrence Jenkins, MD

**ASSISTANT:** \*\*\*

**ANESTHESIA:** General

**EBL:** 10\*\*\* mL

**DRAINS:** None

**INDICATION**: The patient is a @AGE@-year old white male who has chronic left\*\*\* orchalgia who has failed conservative measures. He had responded robustly to that spermatic cord block. We disucssed a left\*\*\* sided procedure, its pros and cons, risks and benefits and he requested to proceed.

**PREOPERATIVE PREPARATION**: The patient was seen in the office prior to surgery, had his preoperative laboratory testing performed. He completed his consent form and he verbalized understanding of the risks, potential complications and outcomes.  Prior to the surgery he had an intravenous line commenced and had the administration of 2gm of cefazolin.

**OPERATION**:  The patient was brought into the operative room and was laid supine upon the operating table and induced under general anesthesia. His genitalia were shaved.  He was prepped and draped in a standard fashion. The operating microscope was draped with a sterile cover.

A 2-3 cm transverse incision was made in the left\*\*\* subinguinal area.  This was carried down to subcutaneous layers using a combination of cautery and blunt dissection.  The spermatic cord was identified and it was delivered into the wound with a Babcock clamp. Posterior, medial, and lateral cautery was performed to ligate branches of the ilioinguinal and genitofemoral nerves around the cord.   Local anesthetic was injected around the wound with 0.5% ropivicaine and 5 mL was infiltrated into the spermatic cord.

The cremasteric  muscle layer, the peri-vasal sheath and the posterior lipomatous tissues with all associated nerve fibers were all cauterized and divided completely. All\*\*\* veins other than the vasal veins were clipped and divided. A large testicular artery and two\*\*\* small arteries and the deferential artery were all preserved. 3\*\*\* medium size lymphatics were preserved.

Real-time intra-operative Doppler ultrasound arterial mapping was performed during the case to ensure no injury to the arteries. On completion, all adventitial tissue was transected and the patient was left with the vasal complex (its artery, veins and lymphatics) plus a arteries and  lymphatics.

Following the achievement of complete homeostasis the spermatic cord was returned to the wound. The wound was irrigated with saline and was closed with interrupted 3-0 Polysorb sutures to Scarpa’s fascia. The skin edges were re-apposed with 4-0 Biosyn suture in a subcuticular fashion.  Dermabond dressing were placed over this.

The patient was extubated in the operating room and was transferred to the recovery room in stable condition.

I, Lawrence Jenkins, MD, MBA, was present for the entire procedure.

Glphenylephrine

Provided a prescription and education for home self injection of phenylephrine. I stressed the risks of increasing heart rate, blood pressure rise, potential complications of bruising, stroke, heart attack and palpitations especially if too high a dose is given. He will only use 0.5 mL of 500 mcg/mL once, and can repeat the injection after 10 minutes if not successful. I did instruct him to not use more that 1 mL total.

Biothesiometryreport

@NAME@

@DOB@

**Biothesiometry - Vibration Perception Testing** CPT 95907

**Indication**: Sexual dysfunction, decreased penile sensation

**Objective**: evaluation of penile sensation and dorsal nerve sensory function.

**Procedure**: With the patient relaxed in supine position objective assessment of penile vibratory sensation was performed using the Bio-thesiometer (Model PVD) placing the handpiece on the pulp of the index fingered as reference sensory thresholds and then followed by determination of penile sensory thresholds on the right and left sides of the glans penis and penile shaft. Vibratory amplitude was gradually increased from a zero reading until the sensory threshold was reached. Multiple readings were take at each location. The absolute amplitude of each threshold is recorded below and corresponds to its value in microns (see calibration table). The amplitude obtained was compared to a set of known age-dependent non-neurogenic potent controls seen below (Padma-Nathan, 1988).

Index Finger: Left: \*\*\* Right: \*\*\*

Penile Shaft: Left: \*\*\* Right: \*\*\*

Glans Penis: Left: \*\*\* Right: \*\*\*

**Impression**: \*\*\*

@ME@

**Penile Biothesiometry**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Age Range | % | Mean Age | Right Finger | Left Finger | Right Shaft | Left Shaft | Glans | Frequency of  Coitus/ month |
| 17-29 | 15 | 23±-4 | 5 | 5 | 5 | 5 | 6 | 3±3 |
| 30-39 | 22 | 34±3 | 5 | 5 | 6 | 6 | 7 | 5±5 |
| 40-49 | 31 | 44±3 | 5 | 5 | 6 | 6 | 7 | 4±2 |
| 50-59 | 31 | 54±3 | 6 | 6 | 8 | 8 | 9 | 3±2 |
| 60-69 | 10 | 64±3 | 6 | 6 | 9 | 9 | 10 | 3±3 |
| 70 | 9 | 73±3 | 7 | 7 | 14 | 14 | 16 | 2±2 |

Cryocondyloma

**ATTENDING**: Frank Begun

**RESIDENT**:

**PREOPERATIVE DIAGNOSIS(ES)**: condyloma acuminatum

**POSTOPERATIVE DIAGNOSIS(ES)**: same

**PROCEDURE PERFORMED**: cryotherapy with liquid N2

**ANESTHESIA**: none

**PROCEDURE DETAILS**:

Multiple condyloma lesions \*\*\* were treated with liquid N2. No complications.

The entire procedure was performed by Dr. Frank Begun with the assistance of Dr.\*\*\*

**ESTIMATED BLOOD LOSS**: N/A

**FLUIDS**: N/A

**SPECIMEN(S) REMOVED**:N/A

**CONDITION**: Good

**COMPLICATIONS**: None

**PLAN**: RV PRN

Nbanturethroplastydisc

I had a long discussion with this patient about his anterior urethral stricture. We talked about the options of a direct vision internal urethrotomy or a formal urethroplasty. I shared with him the data from 2017 American Urological Association guideline on urethral stricture. I quoted a success rate of 50% as a long term durable treatment for a DVIU. I told him that we consider DVIU a palliative option although it is feasible option in certain situations. We talked about the option of a urethroplasty. The success rate for a buccal only repair (over 2 cm stricture) is 85%, and for a primary anastomosis is 85-95%. We then discussed that some long strictures or in the presence of previous attempts at urethral reconstruction (e.g. Hypospadias) we consider a 2 stage approach using buccal graft. We also discussed perineal urethrostomy which is re-routing the urethra to an opening in the perineum. I told him that we reserve this option for severe/long strictures or patients with several comordities where a reconstruction is not safe. We discussed that the long term results are as well as urethroplasty with excellent durability and relatively high level of patient satisfaction.

We talked about the possible complications including stricture recurrence, perineal pain and ejaculatory dysfunction which generally resolve by 6 months, worsening ED (usually due to underlying disease pre-operatively), chronic oral pain or tightness with buccal harvest, and compartment syndrome from lithotomy positioning in the OR (1/500).

We also discussed other options for urethral stricture management including chronic intermittent self obturation following a DVIU or or an indwelling suprapubic tube.

We discussed risks/benefits of all these approaches and he asked several excellent questions which I answered to his satisfaction. Eventually he elected \*\*\*

Nbburied

I discussed buried penis with the patient and reviewed all management options.

We discussed that adult buried penis is closely related to obesity, rapid weight loss or other local conditions such as Lichen Sclerosus or penoscrotal Lymphedema. We specifically discussed that this is not a cosmetic procedure and goal is to restore function and allow unobstructed voiding, restore sexual function and decrease risk of infection.

I told him and depending on the severity of his condition medical and surgical options are available. Local topical steroids are effective in the case of Lichen Sclerosus however severe instances will require surgery. We discussed that several decisions are made intraoperatively. It can range from ventral/dorsal slit if the condition is mild with adequate penile skin, removal of diseased tissue (escutcheonectomy, scrotectomy) with or without suprapubic defatting, scrotoplasty and ultimately skin grafting of the penis or scrotum. I told him that urethral/meatal stricture is common once penis is unburied and that require separate treatment strategy if present.

I outlined the hospital course, use of drains, antibiotics, wound care and postop activity restrictions depending on each surgical approach. We reviewed wound complications including soft tissue infection, graft loss, disease recurrence or need for additional procedures. We also discussed that given other comorbidities, there is higher risk of surgical complications such as pulmonary embolus, DVT, pulmonary compromise, sepsis and death. We then discussed the importance of optimizing his concomitant medical conditions if present such as hypertension, diabetes, depression, and obesity and their impact on successful operation and improved wound healing.

He asked excellent questions and I answered them all to his satisfaction. After a long conversation he elected to \*\*\*

Dilation

Description of procedure:

After informed consent was obtained, the patient was taken back to the procedure suite and laid in \*\*\* position. He was prepped and draped in a standard sterile fashion.

A set of "S" shaped urethral dilators was obtained. A guide wire was passed per urethra and advanced into the bladder. Once palpably within the bladder, we began our dilation. We started of passing a \*\*\* fr S shaped dilator over the wire into the bladder, and increased sequentially to a size \*\*\* fr dilator.

Once this was complete, a \*\*\* fr council tip catheter was inserted over the wire. Once return of urine was seen, the wire was removed and the balloon was inflated.

The patient tolerated the procedure well.

Foleywire

The patient was taken back to the procedural suite and placed in a supine position. He was prepped and draped in a standard sterile fashion. A sensor was was introduced through his exisiting \*\*\* Fr council tip foley catheter. Fluoroscopy was \*\*\* used to confirm appropriate confirmation was wire location. The foley was then withdrawn over the wire. A \*\*\* fr council tip foley catheter was then advanced over the until return of urine was seen. The wire was removed and the balloon was inflated. The foley was hooked up to a drainage bag at the end of the procedure.

Fufounier

Patient

@NAME@

MRN: @MRN@

DOB: @DOB@

Referring physician

@REFADDR@

Primary care provider

@PCP@

@CC@

HPI: I had the pleasure of seeing your patient @NAME@ today in the Ohio State University Urology clinic in follow-up for his \*\*\*. As you know, @HE@ is a very pleasant @AGE@ male who unfortunately had Fournier's gangrene and underwent debridement in the past and is here today for follow up.

He required \*\*\* trips to the OR for debridements. His reconstruction involved \*\*\* grafts and \*\*\* primary closure. The date of his final reconstruction was \*\*\*.

Culture results: \*\*\*

Discharge antibiotics: \*\*\*

Grafting required: \*\*\*

Primary closure: \*\*\*

Wound vac: \*\*\*

Permanent sutures: \*\*\*, removed on \*\*\*

Imaging: \*\*\*

PMH/PSH/Meds/All/SH/FH

Reviewed and unchanged except as above. Details scanned into the chart

Review of systems

Reviewed and unchanged except as above. Full details scanned into chart

Vital signs

@VS@

Physical Exam

*Constitutional*: Well-developed, well-nourished without distress.

*Cardiovascular*: RRR, intact distal pulses.

*Pulmonary/Chest*: Effort normal. No respiratory distress. He has no wheezes.

*Abdominal*: Soft and non-tender. He exhibits no distension and no mass. There is no rebound and no guarding or CVAT. No pain along bony spine.   
*Genitourinary*: NL phallus without lesions or masses, Testes down BL, smooth, NT, \*\*\*

*Musculoskeletal*: Normal ROM without edema or tenderness.   
*Lymphadenopathy*: He has no cervical or inguinal adenopathy.   
*Neurological*: He is alert.

*Skin*: Skin is warm and dry. No rash noted. He is not diaphoretic. No erythema.   
*Psychiatric*: He has a normal mood and affect. His behavior is normal. Judgment and thought content normal.

Assessment and plan

@NAME@ is a @AGE@ male who presents today in follow-up for fournier's gangrene s/p debridement and reconstruction. He is doing well.

Continue current local wound care with \*\*\*

I answered all the patient's questions to the best of my ability and @HE@ is satisfied with the plan as outlined above. I will be in touch with @HIM@ regarding the above details and @HE@ knows that @HE@ can contact me at any time with any questions or concerns.

Fuuplasty3m

Patient

@NAME@

MRN: @MRN@

DOB: @DOB@

Referring physician

@REFADDR@

Primary care provider

@PCP@

@CC@

History of present illness: @AGE@ male with history of urethral stricture s/p \*\*\* urethroplasty on . The denies perineal/genital or extremity pain or numbness.

The patient has not had any of the following complications: DVT, MI, PE, Hematoma, Wound Infection, Readmission, UTI, Epididymo-orchitis, prostatis, urethral fistula.

Issues with urination include \*\*\*

Patient reported outcome measures:

USS-PROM:

LUTS: \*\*\*/24

Urinary QOL \*\*\*/5

Peeling picture: \*\*\*/4

Overall health: \*\*\*/100

Review of systems: The patient denies Fevers chills nausea vomiting

Constitutional: no acute distress

@VITALSMULTIPLE@

Incision is clean dry and intact

Procedure: Cystoscopy

The patient was prepped and draped in the usual sterile fashion. The scope was advanced to the level of the membranous urethra. There is \*\*\* evidence of recurrent stricture.

Findings: \*\*\*

I personally reviewed and interpreted the results of the above study.

Assessment and plan:

@AGE@ male with urethral stricture status post repair doing well.

We reviewed perineal precautions

We'll have the patient followup in 9 months for flow rate, PVR and questionnaire.

Fuuplastycathremoval

Patient

@NAME@

MRN: @MRN@

DOB: @DOB@

Referring physician

@REFADDR@

Primary care provider

@PCP@

@CC@

History of present illness: @AGE@ male with history of urethral stricture s/p \*\*\* urethroplasty on \*\*\*. The denies BMG, perineal/genital or positioning complaints.

The patient has not had any of the following complications: DVT, MI, PE, Hematoma, Wound Infection, Readmission, UTI, Epididymo-orchitis, prostatis, urethral fistula.

The patient took peri catheter antibiotics.

The foley was removed today after \*\*\* weeks. A VCUG was performed and showed no leak.

Review of systems: The patient denies Fevers chills nausea vomiting

Constitutional: no acute distress

@VITALSMULTIPLE@

Incision is clean dry and intact

Procedure: Voiding cystourethrogram

Procedure: The patient was taken to the operative suite identified and placed in a lateral decubitus position with all pressure points padded. Using existing catheter the patient was filled with approximately 400 mL of contrast. Scout film was obtained prior to this. The patient voided. There is no evidence of extravasation.

Assessment and plan:

@AGE@ male with urethral stricture status post repair doing well.

We reviewed perineal precautions

We'll have the patient followup in 3 months for flow rate, PVR and urethroscopy.

I spent a total of 15 minutes face-to-face with the patient and 10 minutes of that time was spent counseling regarding the diagnosis, the treatment plan and the prognosis.

Newptstricture

Patient

@NAME@

MRN: @MRN@

DOB: @DOB@

Referring physician

@REFADDR@

Primary care provider

@PCP@

@CC@

HPI: I had the pleasure of seeing your patient @NAME@ today in the Ohio State University Urology clinic in referral for evaluation of @HIS@ urethral stricture. As you know, @HE@ is a very pleasant @AGE@ male who has had symptoms of urethral stricture for \*\*\* years. His most bothersome symptoms is \*\*\*. He also complains of

Congenital GU anomalies:\*\*\*

Prior DVIU: \*\*\*

Prior urethroplasty: \*\*\*

Currently voiding status: \*\*\*

Stricture Etiology:

\*\*\* history of STD's

\*\*\* history of straddle injury

\*\*\* history of pelvic fracture

\*\*\* history of foley placement or urethral instrumentation

Patient reported outcome measures:

USS-PROM:

LUTS: \*\*\*/24

Urinary QOL \*\*\*/5

Peeling picture: \*\*\*/4

Overall health: \*\*\*/100

SHIM: \*\*\*

Imaging: \*\*\*

The patient denies any associated changes in fevers, chills, nausea, vomiting, diarrhea or constipation.

@PMH@

@PSH@

@MED@

@ALLERGY@

@SOC@

He denies any family history of genitourinary malignancies or issues.

Review of systems

*Constitutional*: Denies fevers, breathing problems, chills, loss of appetite, weight loss, and pain

*Cardiovascular*: Denies chest pain, varicose veins, heart disease, and high blood pressure

*GI*: Denies abdominal pain, nausea, vomiting, diarrhea, rectal bleeding

*Musculoskeletal*: Denies joint pain, arthritis, back pain

*Neurological*: Denies stroke or seizure

*Eyes*: Denies cataracts and wearing glasses

*Ears/nose/throat/mouth*: Denies nosebleeds, dentures, and loss of hearing

*Hematologic*: Denies anemia, bleeding disease, clotting disease, hepatitis, HIV

*Pulmonary*: Denies asthma, emphysema, lung disease, tuberculosis

*Psychological*: Denies depression or anxiety

Urologic ROS:

Previous urologic surgery: \*\*\*

H/O hematuria: \*\*\*

H/O UTI: \*\*\*

ED: \*\*\*

H/O stones: \*\*\*

Positioning restrictions: \*\*\*

Vital signs: @VS@

Physical Exam

*Constitutional*: He appears well-developed and well-nourished. No distress.

*HENT*: Head is normocephalic and atraumatic. The patient's neck demonstrates normal range of motion. Neck supple. No tracheal deviation present. No thyromegaly present.

*Cardiovascular*: Normal rate, regular rhythm and intact distal pulses.

*Pulmonary/Chest*: Effort normal. No respiratory distress. He has no audible wheezes. He exhibits no tenderness.

*Abdominal*: Soft. He exhibits no distension and no mass. There is no tenderness. There is no rebound and no guarding or CVAT. No pain along bony spine.   
*Genitourinary*: Penis normal and {Desc; circumcised/uncircumcised:5705}. No signs of Lichen Sclerosus. Right testis shows no mass, no swelling and no tenderness and is descended. Left testis shows no mass, no swelling and no tenderness and is descended. No phimosis, hypospadias, penile erythema or penile tenderness. No discharge noted. No inguinal hernia or scrotal abnormalities.   
*DRE*: \*\*\* Rectal exam shows no external hemorrhoid, no fissure, no mass, no tenderness and anal tone normal. Prostate is not enlarged and not tender. \*\*\*g, no nodules

*Musculoskeletal*: Normal range of motion. He exhibits no edema and no tenderness.   
*Lymphadenopathy*: He has no cervical or inguinal adenopathy.   
*Neurological*: He is alert.

*Skin*: Skin is warm and dry. No rash noted. He is not diaphoretic. No erythema.   
*Psychiatric*: He has a normal mood and affect. His behavior is normal. Judgment and thought content normal.

Labs

UA: \*\*\*

PSA: @RESUFAST(PSA:3)@

Cr: @LASTLABX(creatserum:5)@

Studies

Uroflow: Max flow \*\*\*ml/s, average flow: \*\*\*ml/s, voided volume \*\*\*ml

PVR: \*\*\* ml

Radiology

We reviewed his films as above

ASSESSMENT AND PLAN

@NAME@ is a @AGE@ male who presents today with \*\*\*. I had a long discussion today with the patient about urethral stricture.

I had a long discussion with this patient about his anterior urethral stricture. We talked about the options of a direct vision internal urethrotomy or a formal urethroplasty. I shared with him the data from 2017 American Urological Association guideline on urethral stricture. I quoted a success rate of 50% as a long term durable treatment for a DVIU. I told him that we consider DVIU a palliative option although it is feasible option in certain situations. We talked about the option of a urethroplasty. The success rate for a buccal only repair (over 2 cm stricture) is 85%, and for a primary anastomosis is 85-95%. We then discussed that some long strictures or in the presence of previous attempts at urethral reconstruction (e.g. Hypospadias) we consider a 2 stage approach using buccal graft. We also discussed perineal urethrostomy which is re-routing the urethra to an opening in the perineum. I told him that we reserve this option for severe/long strictures or patients with several comordities where a reconstruction is not safe. We discussed that the long term results are as well as urethroplasty with excellent durability and relatively high level of patient satisfaction.

We talked about the possible complications including stricture recurrence, perineal pain and ejaculatory dysfunction which generally resolve by 6 months, worsening ED (usually due to underlying disease pre-operatively), chronic oral pain or tightness with buccal harvest, and compartment syndrome from lithotomy positioning in the OR (1/500).

We also discussed other options for urethral stricture management including chronic intermittent self obturation following a DVIU or or an indwelling suprapubic tube.

We discussed risks/benefits of all these approaches and he asked several excellent questions which I answered to his satisfaction. Eventually he elected \*\*\*

@HE@ is satisfied with the plan as outlined above. I will be in touch with @HIM@ regarding the above details and @HE@ knows that @HE@ can contact me at any time with any questions or concerns.

Thank you again for allowing me to participate in the care of your patient. Feel free to contact me should the need arise. I will be sure to keep you informed of any changes.

Newngbpt

Patient

@NAME@

MRN: @MRN@

DOB: @DOB@

Referring physician

@REFADDR@

Primary care provider

@PCP@

@CC@

HPI: I had the pleasure of seeing your patient @NAME@ today in the Ohio State University Urology clinic in referral for evaluation of \*\*\*. As you know, @HE@ is a very pleasant @AGE@ male who \*\*\* .

Chief complaint?

Biggest bother?

Cause of NGB? When? Level? Complete/incomplete?

When/how long symptoms?

Progressive or stable?

Bothersome?

Current management:

None

CIC

Drugs: which?

Botox

SNS

SP Tube

Foley

Other

Symptoms/complications of NGB:

Urinary Incontinence

UI day and night? Day only? Night only?

How many pads per day? What type?

How many pad per night? What type?

UUI/SUI/unaware?

UTI

Stones

Upper tract deterioration

Retention

Skin breakdown/decubiti

Other

Sensation in LUT?

Volitional voiding?

Prior therapy?

None

PFE's/behavior

Medications:

Which ones?

How long did you take them?

Did they work at all? Even briefly?

Surgery

what type?

how long ago?

who did it?

did it work even briefly, no better or worse?

new symptoms postop? UTI, UI, OAB, dyspareunia, etc.

Other: (catheter, CIC, plugs, etc.)

Bowel management/regimen

Bowel habits (constipation, diarrhea):

Prior evaluation:

Prior urodynamics/videourodynamics?

Prior Imaging (VCUG, CT, sonography, MRI)?

Prior cystoscopy?

Prior PVR checked? How much?

Sexual dysfunction?

Sexually active?

Patient reported outcome measures:

NBBS questionnaire

Imaging: \*\*\*

The patient denies any associated changes in fevers, chills, nausea, vomiting, bowel or bladder symptoms, diarrhea or constipation.

@PMH@

@PSH@

@MED@

@ALLERGY@

@SOC@

He denies any family history of genitourinary malignancies or issues.

Review of systems

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*Pulmonary*: Denies asthma, emphysema, lung disease, tuberculosis

*Psychological*: Denies depression or anxiety

Urologic ROS:

Previous urologic surgery: \*\*\*

H/O hematuria: \*\*\*

H/O UTI: \*\*\*

ED: \*\*\*

H/O stones: \*\*\*

Positioning restrictions: \*\*\*

Vital signs: @VS@

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*DRE*:

*Musculoskeletal*: Normal range of motion. @HE@ exhibits no edema and no tenderness.   
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Labs

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PSA: @RESUFAST(PSA:3)@

Cr: @LASTLABX(creatserum:5)@

Studies

Uroflow: Max flow \*\*\*ml/s, average flow: \*\*\*ml/s, voided volume \*\*\*ml

PVR: \*\*\* ml

Radiology

We reviewed his films as above

ASSESSMENT AND PLAN

@NAME@ is a @AGE@ male who presents today with \*\*\*. I had a long discussion today with the patient about \*\*\*.

I answered all the patient's questions to the best of my ability and @HE@ is satisfied with the plan as outlined above. I will be in touch with @HIM@ regarding the above details and @HE@ knows that @HE@ can contact me at any time with any questions or concerns.

Thank you again for allowing me to participate in the care of your patient. Feel free to contact me should the need arise. I will be sure to keep you informed of any changes.

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: bladder lesion

POSTOPERATIVE DIAGNOSIS: same

OPERATION:

1. Cystoscopy

2.  Cold cup biopsy of bladder lesion and fulguration

ANESTHESIA: General

Findings: \*\*\*

ANESTHESIA: General

CLINICAL INDICATIONS: @AGE@ year old with history of \*\*\* . @HE@ is scheduled for above mentioned procedure. @HE@ understands the risks including stricture, recurrence of bleeding, pain, among others and wishes to proceed.

DESCRIPTION OF PROCEDURE: @HE@ was taken to the operating suite, identified, and was given appropriate perioperative antibiotics. @HE@ was placed in the lithotomy position with all pressure points well padded.

We placed a 21f rigid cystoscope in the bladder, Pan cystoscopy revealed \*\*\*

We took biopsy of the lesion with a rigid cold cup and the area was completely fulgurated. We drained the bladder multiple times under direct vision and the hemostasis was excellent.

This concluded the procedure, we placed a \*\*\* foley catheter in the bladder.

The patient tolerated the procedure  well, was awakened and transferred to PACU in stable condition.

SURGICAL ATTENDANCE: I, the attending physician, Dr. Nima Baradaran, MD, was present and scrubbed throughout the entire case.

Disposition: Will contact the patient with path findings

Opburiedpenisrepair

DATE OF OPERATION: @DATE@

PREOPERATIVE DIAGNOSIS: Acquired buried penis

POSTOPERATIVE DIAGNOSIS: Same

OPERATION:

1. Buried penis repair, escutcheonectomy (30cm x 10cm suprapubic fat pad removal).

FINDINGS:

ANESTHESIA: General

INDICATIONS FOR PROCEDURE:  The patient is a @AGE@ gentleman with

history of buried penis with complete sexual dysfunction as a result of who requests repair. \*\*\*

He was apprised the risks and benefits including all the risks of anesthesia, infection, and wound

complications, as well as DVT, PE, and death, given his weight and body

habitus.  He was willing to proceed.

DESCRIPTION OF PROCEDURE:  After informed consent was obtained, he was

transferred to operating room, placed supine on the table.  General

endotracheal intubation was induced.  Appropriate preop antibiotic,

was administered.  He was put in supine open leg position,

prepped and draped in normal sterile fashion. Formal time out was performed.

During exam under anesthesia, he had a prominent suprapubic fat pad

draping over his entire penis and pubic bone, which has led to the penis

to be buried.  \*\*\* We decided that he does\*\*\* need skin grafting

We then marked our shield incision on the suprapubic fat pad, leaving a

3 cm margin from the base of the penis cephalad.  We made the incision

with a knife and carried down the dissection toward the anterior rectus

fascia with a combination of electrocautery and sharp dissection.  We

encountered few large veins that we ligated and controlled with

electrocautery.  We developed the flap and dissected down toward the

rectus fascia, and eventually delivered the specimen in 1 piece.  This

was approximately 5 pounds. We did not encounter the cords during dissection.  We then

Irrigated the wound copiously with antibiotic solution. examined our wounds.

At this junction, we identified the

Penopubic junction and dissected down the subcutaneous tissue with a combination

of electrocautery and defatted the pubic bone.  I placed four 2-0

Prolene stitches to the soft periosteum of the pubic bone anteriorly and

tacked this to the skin at the penoscrotal junction.  This tacked the

skin nicely all the way down to the pubic bone and unburied the penis

dorsally.

Excellent hemostasis was achieved and we brought the skin together with numerous interrupted 2-0

Vicryl sutures.  This brought the skin edges together with no tension in the midline.

I then placed a 16-French Foley catheter in the bladder for

postop recovery and inflated the balloon with 10 cc of water.  The skin

closure was complete. This was the completion of the case.  He was awakened

by the anesthesia team and transferred to PACU in stable condition.

I, Nima Baradaran, MD, was present and scrubbed during the entire case.

Opcircumcision

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Phimosis.

POSTOPERATIVE DIAGNOSIS: Phimosis.

OPERATION: Circumcision

FINDINGS: Uncomplicated circumcision

ANESTHESIA: General

Clinical indication: @AGE@ M with history of phimosis, desires circumcision. He understands the risks including bleeding, infection, poor cosmetic results, penile and scrotal tethering, chronic pain, sexual dysfunction among others and wishes to proceed.

Procedure: He was taken to the operative suite and draped and prepped in the usual fashion. Formal time out was performed and appropriate IV antibiotic was administrated.

A 2 incision sleeve technique was used. The skin was removed, leaving the dartos fascia. The skin was re approximated with 3-0 vicryl interrupted stitches.

The wound was dressed. The patient tolerated the procedure well and transferred to PACU in stable condition.

SURGICAL ATTENDANCE: I, the attending physician, Dr. @ME@, was present and scrubbed throughout the entire case.

Opcystectomysimpleconduit

DATE OF OPERATION: @DATE@

PREOPERATIVE DIAGNOSIS: \*\*\*

POSTOPERATIVE DIAGNOSIS: \*\*\*

OPERATION:

1. Cystectomy.

2. Ileal conduit creation.

3. Omental flap harvest to fill the cavity

FINDINGS: \*\*\*

ANESTHESIA: General

CLINICAL INDICATIONS:The patient is a @AGE@ {MALE/FEMALE:23217} with a

history of \*\*\*.

After discussing various treatment options, the patient wishes to proceed with cystectomy and ileal conduit. He understands the risks, including bleeding,

infection, bowel injury, small bowel obstruction, ureteral stenosis,

renal failure, death, among others, and wishes to proceed.

PROCEDURE: He was taken to the operative suite, identified, an

epidural {WAS:18477} placed by the anesthesia team, and he was intubated.

He was placed in the supine position with all pressure points well

padded. Both arms were out in anatomic position and padded.

An incision was made from the patient's pubic bone up to 1 inch above his umbilicus. In the preoperative area, the urostomy was marked in the lower right abdominal quadrant.

We dissected down through Scarpa's, we located the fascia and its decussation in between the muscle bellies. We dissected down through the transversalis into the abdominal cavity. There were {MILD/MODERATE/SEVERE:20080} adhesions that we carefully took down with sharp cold dissection for \*\*\* minutes.

After this dissection was complete, we identified bilateral ureters as they crossed over the iliac vessels, and we dissected them down to their insertion into the

bladder. These were transected. We developed a plane between the

sacral promontory and the sigmoid, and passed the left ureter to the

right side. We then proceeded to perform our cystectomy. We

performed a simple cystectomy by incising and bivalving the dome of

the bladder, carrying it down to its junction with the rectum. We

then used a LigaSure to resect the lateral walls and dome of the

bladder, until we were left with a small component of bladder that

was underneath the pubic bone. We then used electrocautery to obliterate

the small amount of remaining mucosa. Careful hemostasis was

achieved.

We then turned our attention to the creation of our ileal conduit.

The ileocecal valve was identified. There was a knuckle of bowel

that was adhesed to the sidewall, and more lysis of adhesions was

performed. 20 cm from the ileocecal valve, we isolated a 15 cm

segment of bowel. We identified the mesentery and used LigaSure to

isolate the bowel, and loads of the GIA 80 staple. We reanastomosed

the small bowel with a side-to-side anastomosis using a combination

of GIA 80 and TA 60 staplers. The butt-end of the anastomosis was

reinforced with lemberted sutures.

We then performed our ureteral conduit anastomosis, placing the left

ureter on the left side of the conduit and the right ureter on the

right side of the conduit. The conduit was oriented in the

pro-peristaltic position. The mucosa was lifted with a 4-0 chromic

stitch and incised. We then everted the mucosa in the standard

fashion, and performed interrupted stitching for the anastomosis. A

single J stent was placed into the kidney and out the conduit.

We then turned our attention to brooking our conduit by taking a

dime-sized piece of skin, dissecting down to the fascia, making a T

incision, 3-0 Vicryls were placed in the crotch of the T. The

conduit was then delivered through the hole in the abdominal wall.

We then brooked the conduit with interrupted 3-0 Vicryl. We placed a 20fr red rubber catheter and secured it to the conduit mucosa with 4-0 Chromic sutures. We secured the stents in place as well with stitches.

We then turned our attention to the omentum, taking down the right

gastroepiploic attachments to the greater curve of the stomach. We

then brought the omentum down and parachuted our flap into the defect

created by the cystectomy, suturing it in with 4-0 Vicryls.

We then placed a closed-suction drain in the left lower quadrant. The wound

was irrigated with antibiotic solution. The fascia was closed with a combination of running and interrupted 0 PDS, subcutaneous fat was approximated with 3-0 Vicryl and the skin was stapled. A urostomy appliance was placed. The patient tolerated the procedure well and was awakened and transferred to PACU in stable condition.

SURGICAL ATTENDANCE: I, the attending physician, Dr. @ME@, was present and scrubbed throughout the entire case.

Opcystoclotevac

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Hematuria

POSTOPERATIVE DIAGNOSIS: same

OPERATION:

1. Cystoscopy, evacuation of clots

2.  Transurethra resection of prostate tissue and fulguration

ANESTHESIA: General

Findings: \*\*\*

ANESTHESIA: General

CLINICAL INDICATIONS: @AGE@ year old male with history of \*\*\* . He has had significant hematuria and has failed conservative management and is scheduled for cysto, clot evacuation and fulguration of the bleedlngs. He understands the risks including stricture, recurrence of bleeding, pain, among others and wishes to proceed.

DESCRIPTION OF PROCEDURE: He was taken to the operating suite, identified, and was given appropriate perioperative antibiotics. He was placed in the lithotomy position with all pressure points well padded.

We placed a 23f resectoscope in the bladder, there was evidence of foley trauma along the length of the urethra but there was no stricture or bleeding. We encountered a large clot burden that required hand irrigation with Toumy syringe. We evacuated approximately \*\*\*cc of old organized clot.

Cysto showed \*\*\*

We required \*\*\* minutes of fulguration of bleeders

This concluded the procedure, we placed a \*\*\* foley catheter in the bladder.

The patient tolerated the procedure  well, was awakened and transferred to PACU in stable condition.

SURGICAL ATTENDANCE: I, the attending physician, Dr. Nima Baradaran, MD, was present and scrubbed throughout the entire case.

Disposition: \*\*\*

Opdistaluplasty

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Traumatic hypospadias.

POSTOPERATIVE DIAGNOSIS: Same

OPERATION: Urethroplasty

FINDINGS: \*\*\*

ANESTHESIA: General

Clinical indication: @AGE@ M with history of traumatic hypospadias from prolonged catheterization. He understands the risks including bleeding, infection, poor cosmetic results, chronic pain, sexual dysfunction among others and wishes to proceed.

DESCRIPTION OF THE PROCEDURE:

The patient was taken back to the operating

room and laid in a supine position.  General anesthesia was administered

per care of Anesthesia Service.  Time-out was done and the patient was

appropriately identified.  He was prepped and draped in a standard

sterile fashion.  Perioperative antibiotics were administered.  We

started the procedure off by outlining the traumatic hypospadias

distally.  The outline of the incision that was marked was an inverted U

going from the coronal junction cephalad around the urethral plate.  The

skin was incised sharply with a Beaver blade.  We developed deep glans

wings as local advancement flaps to be used later in the case.  We

undermined the urethral plate in order to get good mobility to

tubularize this.  Once this had been mobilized, it was approximately 3

cm in diameter and we knew that a flip flap distal urethroplasty would

not be required.  Therefore, we completed the incision going proximally

around the neomeatus from the traumatic hypospadias.  The plane between

dartos and Buck's fascia was developed with both blunt and sharp

dissection.  We then closed the urethra distally in an interrupted

fashion with 5-0 PDS suture.  Aside from the distal portion the

remainder of the urethral plate was run closed with a 5-0 PDS suture.  A

2nd layer of peri-urethral tissue was used to cover our initial repair site with

interrupted 4-0 Polysorb suture.  The glans wings were then closed in an

interrupted fashion with 4-0 Vicryl suture.  The urethral mucosa was

matured to the surrounding glans skin with 4-0 Monocryl suture.  Once

this was done, the glans skin was closed in an interrupted fashion with

4-0 Monocryl suture.  The distal shaft still had a wound present.  A dog

ear was going to be created in closure so this was subsequently trimmed

to get better cosmesis with sharp dissection.  Dartos fascia was closed

in a running fashion with a 4-0 Vicryl suture.  The skin was closed in

an interrupted fashion with 4-0 Monocryl suture.  A compression dressing

was applied.  The suprapubic tube that had been placed early in the case

was hooked up to a drainage bag.  A circumferential ring block was given

at the end of the case to provide appropriate analgesia.  Sterile

dressings were applied.  He was awoken per care of Anesthesia Service.

Taken to recovery in stable condition.

Ausexplant

OPERATIVE REPORT

DATE OF OPERATION: \*\*\*

ATTENDING SURGEON: @ME@, M.D.

ASSISTANCE: \*\*\*

PREOPERATIVE DIAGNOSIS: Urinary incontinence with eroded artificial

urinary sphincter.

POSTOPERATIVE DIAGNOSIS: Urinary incontinence with eroded artificial

urinary sphincter.

OPERATION:

1. Cystoscopy.

2. Explantation of artificial urinary sphincter.

3. Partial urethrectomy.

4. Anastomotic urethroplasty.

CLINICAL INDICATIONS: The patient is an @AGE@-year-old man with a

history of prostate cancer, status post radiation therapy, complicated by urinary incontinence who was treated with an artificial urinary sphincter.

Unfortunatley he was found to have the AUS cuff erosion into the urethra and is scheduled for explantation of the device.

FINDINGS: \*\*\*

PROCEDURE: The patient was taken to the operative suite, identified,

and placed in the supine position after general anesthesia was induced by the anesthesia team. Formal time-out was performed, he was positioned in lithotomy with all pressure points carefully padded, and preoperative antibiotics were administered.

An incision was made between the patient's scrotum and anus, and we identified the cuff. The cuff was excised and the pump was delivered. There {WAS:18477} evidence of gross puss along the device pump and tubing.

We then made a counterincision in the patient's abdominal region, and excised the

Pressure regulating balloon along with all attached tubings.

The wound was copiously irrigated with Bacitracin solution. The abdominal fascia was closed with interrupted 2-0 PDS.

We then assessed the urethra carefully, We attempted to place a 14-French and 16-French Foley, but there was an obvious defect at the level of the patient's cuff erosion. We mobilized the urethra circumferentially off the corporal bodies to exposed this. We debrided the devitalized portions of the urethra mobilized the urethra proximally and distally to provide tension free anastomosis. We then performed a formal urethroplasty using interrupted 4-0 Vicryl sutures to re approximate the urethral epithelium and overlying spongiosum after placing a 14f foley catheter into the bladder. The portion of the urethra was sent to Pathology, along with the explanted device.

\*\*\* We then placed hemostatic agent over the wound after it was irrigated. We left a 1/4-inch Penrose. The wound was closed with interrupted 4-0 Vicryl stitch.

SURGICAL ATTENDANCE: I, @ME@ am the attending physician and was scrubbed and performed the procedure

Frenuplasty

Procedure: frenuloplasty

Indication: @AGE@ y.o. male with frenular tethering requesting repair. Discussed all options including circumcision and he wanted to proceed with frenulectomy. Risks including scar, bleeding, infection, change in penile sensation and damage to other structures were discussed.

After informed consent was obtain he was transferred to the procedure room, local anesthesia was performed with 0.5% plain Marcaine in the deep dorsal penile block and in the frenulum area.

A releasing horizontal incision was made on the frenulum and it released the glans nicely. A single running 4-0 vicryl suture was used to close the incision longitudinally. dermabond was applied. Hemostasis was excellent. Gentle compression dressing was applied with coban. He tolerated the procedure well.

Patient to remove dressing in 4 hours. Discussed risk of paraphimosis and he will monitor this closely. Discussed ice back and pain medication as needed.

RTC in 4 weeks

Opgracilisharvest

With the patient in lithotomy position, the entire {LEFT-RIGHT-NA:20207} thigh is prepped and draped in the normal sterile fashion. The leg is slightly abducted with the knee flexed to assist in identification of the muscle. We identified the gracilis muscle with palpation just inferior to the adductor longus and sartorius. We marked the expected course of the muscle in the inner thigh between ischiopubic ramus and the medial condyle of the Tibia. We marked the expected site of the dominant vascular pedicle of medial circumflex artery about 10 cm distal from the pubic tubercle/inguinal crease. We also marked the secondary pedicles about 10 cm distal to the primary pedicle on the skin. We then made an incision about three fingers posterior and parallel to this line and distal to the pedicle insertion. We identified the gracilis at the base of the

wound after the subcutaneous fat and muscular fascia were divided. We identified the expected location of the main pedicle and confirmed this with doppler signals. We dissected the muscle circumferentially at the belly of the muscle and placed a penrose drain around it for retraction. We continued the dissection distally towards the insertion to the tibial condyle and applied metal clips to small perforating branches once encountered. We isolated the round and long gracilis tendon at the insertion site and a 0 Vicryl staysuture was placed around the tendon. Once we confirmed the muscle we transected the tendon with electrocautery.

We then continued the blunt dissection proximally to the level of the pedicle. We did not skletenize the entire pedicle in order to avoid inadvertent injury. We then created a tunnel under the skin towards the perineal opening to pass the muscle. This was done bluntly and the tunnel was enlarged to easily accommodate two fingers which would have enough room for the muscle to pass under no pressure. We brought a tonsil clamp and grabbed the stay suture and brought the flap into the perineal wound. We then rechecked the pedicle's doppler signal and confirmed that the muscle has strong pulse and is not twisted. We then used 2-0 Vicryl sutures to parachute the muscle deep into the perineal cavity to cover the desired structures.

2 Jackson Pratt drains was placed in the thigh incision and wound was irrigated with antibiotic solution and closed in 3 layers and surgical glue was applied.

Ophydrocelectomy

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Hydrocele.

POSTOPERATIVE DIAGNOSIS: Hydrocele

OPERATION: Hydrocelectomy

FINDINGS: \*\*\*

EBL: 25

COMPLICATIONS: None

INDICATION: @AGE@ @SEX@ with bothersome symptoms who agreed to undergo the above named procedure after discussion of the alternatives, risks and benefits. They include but not limited to infection, bleeding, damage to cord structures or adjacent tissues. Informed consent was obtained.

PROCEDURE: The patient was taken to the operating room and placed supine on the operating table. Pre-operative antibiotics were administered. Bilateral lower extremity SCDs were placed. After induction of general anesthesia the patient was maintained in supine position. The patient's genitalia was trimmed, prepped and draped in a sterile fashion and a time-out was performed.

We began the procedure by making a \*\*\* cm incision on the scrotal wall through the skin with a scalpel and carried this down to the tunica vaginalis on the {LEFT/RIGHT/BILATERAL:20202} side. The tunica vaginalis was completely swept free of the overlying tissue and testicle delivered out of the scrotal wound. Electrocautery was used to come through the tunica vaginalis and the hydrocele fluid drained. Cautery was used to open the remainder of the tunica vaginalis to prevent recurrence of the hydrocele. Edges were fulgurated with electrocautery. Hemostasis was maintained throughout the case.

\*\*\* Spermatocele

Care was taken to avoid the epididymis. Once the edges were completely dry I again ensured excellent hemostasis and began the closure. When replacing the testicle into the scrotal sac care was taken to ensure that the vas was posterior and the spermatic cord anterior. The dartos muscle was closed with 2-0 Vicryl suture followed by a second layer of dartos closure due to large dead space. I closed the skin with 4-0 chromic in an interrupted horizontal mattress fashion. \*\*\* drain was placed. The patient tolerated the procedure well and at the end of procedure a {LEFT/RIGHT/BILATERAL:20202} spermatic cord block with 0.5\*\*\*% Marcaine as well as local infiltration near the incision was performed. The patient was awakened, extubated and taken to recovery unit without difficulty.

At the end of the procedure all instrument, needle and sponge counts were correct x 2.

I will see him back in clinic in 3-4 weeks for wound check

SURGICAL ATTENDANCE: I, the attending physician, Dr. @ME@, was present and scrubbed throughout the entire case.

Opausinsertion

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Stress urinary incontinence.

POSTOPERATIVE DIAGNOSIS: Stress urinary incontinence.

OPERATION: Placement of artificial urinary sphincter, AMS 800,

cuff size \*\*\* cm, 61-70 cm H2O pressure regulating balloon placed in \*\*\* lower quadrant.

ANESTHESIA: GET

CLINICAL INDICATIONS: The patient is a @AGE@ man with a

history of \*\*\* stress urinary incontinence. After discussing treatment options, the

patient wishes to proceed with artificial urinary sphincter placement. He understands the risks involved, including infection, erosion, chronic pain, inability of the device to fix his

incontinence, among others, and wishes to proceed.

DESCRIPTION OF PROCEDURE: He was taken to the operating suite,

identified and intubated by the anesthesia team. He was placed in

the lithotomy position with all pressure points well padded. He had bilateral sequential compression devices placed and received periprocedure IV antibiotics per AUA guidelines. An incision was made between the patient's scrotum and anus that was

approximately 3 cm. We dissected down through the bulbocavernosus and bulbospongiosus muscle fibers to expose the corpora spongiosum. A 1 cm window on the dorsal surface of the spongiosum was created, separating the corpora

spongiosum from the underlying tunica albuginea of the corpora

cavernosa. This was then sized to be \*\*\* cm. An incision was then

made on the patient's \*\*\* lower abdominal wall. We dissected down

to the level of the fascia, and 2-0 PDS stay stitches were placed and

the fascia incised sharply. A space was created for the reservoir

underneath the fascia. The reservoir was placed and filled with 23.5

mL of sterile normal saline. We then tunneled the pump down into the scrotum on the

patient's right side using blunt dissection with a ring forceps. The tubing was passed. The cuff was then placed around the urethra, and the tubing passed with the trocar to

the abdominal incision. Two connectors were placed and the device

was cycled. We were able to see the device distend. It was locked

in the open position and placed a 12fr foley catheter in the bladder.

The patient's perineal wound was then closed in 3 layers with 4-0 Vicryl and the abdominal wound closed in 2 layers. Skin glue was applied to the abdominal wound. The patient tolerated the procedure well and was transferred to PACU in stable condition.

SURGICAL ATTENDANCE: I, the attending physician, Dr. @ME@, was present and scrubbed throughout the entire case.

Opaustranscorp

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Stress urinary incontinence.

POSTOPERATIVE DIAGNOSIS: Stress urinary incontinence.

OPERATION:

1. Creation of tunica albuginea tissue flaps. (CPT 14040)

2. Transcorporal placement of artificial urinary sphincter

Findings:

AMS 800, cuff size \*\*\* cm, 61-70 cm H2O PRB placed in {left/right:311354} lower quadrant

ANESTHESIA: GET

CLINICAL INDICATIONS: The patient is a @AGE@man with a

history of stress urinary incontinence following \*\*\* . After discussing treatment options, the patient wishes to proceed with artificial urinary sphincter

placement. He understands the risks involved, including infection,

erosion, chronic pain, inability of the device to fix his

incontinence, among others, and wishes to proceed.

DESCRIPTION OF PROCEDURE: He was taken to the operating suite,

identified and intubated by the anesthesia team. He was placed in

the lithotomy position with all pressure points well padded. He had bilateral sequential compression devices placed and received appropriate periprocedure IV antibiotics per AUA guidelines.

An incision was made between the patient's scrotum and anus that was

approximately 3 cm. We dissected down through the bulbocavernosus and bulbospongiosus muscle fibers to expose the corpora spongiosum.

The lateral surface of the corpora were dissected free for flap creation. A 1 x 2 cm flap on the back surface of the corpora spongiosum using tunica albuginea was created. With 2-0 PDS stitch, the posterior corporal defect was advanced and closed.

A sizer was used to identify cuff size.

This was then sized to be \*\*\* cm. An incision was then

made on the patient's {left/right:311354} lower abdominal wall. We dissected down

to the level of the fascia, and 2-0 PDS stay stitches were placed and

the fascia incised sharply. A space was created for the reservoir

underneath the fascia. The reservoir was placed and filled with 23.5

mL of sterile fluid. We then tunneled the pump down into the scrotum on the

patient's {left/right:311354} side. The tubing was passed. The cuff was then

placed around the urethra, and the tubing passed with the trocar to

the abdominal incision. Two connectors were placed and the device

was cycled. We were able to see the device distend. It was locked

in the open position and a 12fr foley was placed in the bladder.

The patient's perineal wound was then closed

in 3 layers with 4-0 Vicryl and the abdominal wound closed in 2

layers. Skin glue was applied to the abdominal wound. The patient

tolerated the procedure well and was transferred to PACU in stable condition.

SURGICAL ATTENDANCE: I, the attending physician, Dr. @ME@, was present and scrubbed throughout the entire case.

Opmeatoplasty

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Distal urethral stricture involving the fossa navicularis

POSTOPERATIVE DIAGNOSIS: Distal urethral stricture involving the fossa navicularis

OPERATION:

1. Cystoscopy.

2. Urethroplasty

ANESTHESIA: General

Findings: \*\*\*

CLINICAL INDICATIONS: The patient is a @AGE@ man with a

long history of distal urethral stricture disease involving the fossa navicularis and meatus. He has undergone previous dilations but it is suffering from obstructive symptoms and requests a more definitive repair. After discussing all treatment

Options including a total reconstruction, the patient wished to proceed with urethroplasty with subcoronal meatus. He understands that he may continue to have urine spraying. the risks including recurrence, sexual dysfunction, chronic pain, and urinary dribbling, among others and wishes to proceed. We also discussed possibility of buccal graft harvest and it's complications including damage to salivary duct, pain, change in sensation if necessary before the operation.

PROCEDURE: : He was taken to the operative suite, identified, and

placed in supine position with all pressure points well padded.Formal time out was performed and appropriate IV antibiotic was administered per AUA guidelines. A

2-0 silk was placed in the patient's glans for retraction. We started by taking a

Metzenbaum scissors and dissecting through the patient's frenulum to

the subcoronal region. There was a nice capacious urethra proximally that we

were able to pass a 22 bougie without difficulty. We then performed pan-cystourethroscopy and ensured no other strictures were present proximally. Prostate was \*\*\*, bladder had {MILD/MODERATE/SEVERE:20080} trabeculations but no stones or lesions.

We then advanced the patient's urethral mucosa to the skin and performed an

interrupted anastomosis with 4-0 Vicryl. Bacitracin was applied to

the wound, and a 14-French Foley catheter placed.

The patient tolerated the procedure well, was awakened and transferred to PACU in stable condition.

SURGICAL ATTENDANCE: I, the attending physician, Dr. @ME@, was present and scrubbed throughout the entire case.

Opperinealurethrostomy

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Complex anterior urethral stricture disease

POSTOPERATIVE DIAGNOSIS: Complex anterior urethral stricture disease

OPERATION:

1. First stage urethroplasty to create perineal urethrostomy

2. Cystoscopy.

ANESTHESIA: General

Findings: \*\*\*

CLINICAL INDICATIONS: The patient is a @AGE@ man with a

long history of urethral stricture disease. After discussing all treatment

Options including pan-urethral reconstruction with possible extensive double buccal graft harvest, the patient wished to proceed with a perineal urethrostomy. He

understands the risks including recurrence, need for revision, sexual dysfunction

and chronic pain, among others and wishes to proceed. We also discussed possibility of need for buccal graft harvest and it's complications including damage to salivary duct, pain, change in sensation if neccesary.

PROCEDURE: He was taken to the operating suite, identified and

intubated by the anesthesia team. A formal timeout was performed and appropriate preoperative antibiotic was administrated per AUA guidelines. He was placed in high

lithotomy position with all pressure points were well padded. Patient {does/does not:23800} have an SPT in place.

We began by marking out an inverted U-shaped incision between the ischial tubrocities, palpating the patient's mid bulbar urethra at the apex of the incision. The flap was raised sharply. We came through the fat, going perpendicular to the body, and

entered, unroofing the bulbospongiosus, which was taken. We cleared

off the ventral surface of the corpus spongiosum. A urethrotomy was

made on the corpus spongiosum ventrally until the mucosa was identified.

We proceeded to perform cystoscopy through the new urethrotomy. It demonstrated no further strictures proximally, prostate was found to be \*\*\*, bladder neck was \*\*\*. Bladder was found to have {MILD/MODERATE/SEVERE:20080} trabeculations with no evidence of any lesions or stones. The distance from external sphincter to the proximal edge of our urethrotomy was \*\*\*cm.

The U flap was brought to the urethra and matured with 2-0 Vicryl. Numerous interrupted stitches were placed. Careful hemostasis was achieved and surgical hemostatic agent was applied. A final 16-French Foley catheter was left in place prior to completion of the anastomosis. The wound was washed out, a 1/4 inch penrose drain was left in place, and the wound was closed in 4 layers.

The patient tolerated the procedure well, was awakened and transferred to PACU in stable condition.

SURGICAL ATTENDANCE: I, the attending physician, Dr. @ME@, was present and scrubbed throughout the entire case.

Opgreenlight

POSTOPERATIVE DIAGNOSIS: BPH with obstruction

PROCEDURE PREFORMED: Greenlight laser photovaporization of the prostate

ATTENDING: @ME@

ASSISTANT: \*\*\*

ANESTHESIA: General

TOTAL ENERGY: \*\*\*

FINDINGS: \*\*\*

EBL: Minimal

INDICATIONS FOR PROCEDURE: The patient is a @AGE@ man with BPH/LUTS. Indication for TURP includes \*\*\*. The risks of the procedure including, but not limited to, pain, bleeding, infection, incontinence, bladder neck contracture, recurrence of symptoms, urinary retention, and prolonged foley catheterization, were explained to the patient and he elected to proceed. Informed consent was obtained. He was informed that residents will be participating in the operation.

PROCEDURE IN DETAIL: The patient was taken to the operating room and placed supine on the operating table. Pre-operative antibiotics were administered. Bilateral lower extremity SCDs were placed. After induction of general anesthesia the patient was positioned in dorsal lithotomy. The patient was prepped and draped in a sterile fashion and a time-out was performed.

The procedure was begun using the continuous flow cystoscope easily guiding this into the patient's bladder. The urethra was negative for strictures or lesions. \*\*\*The prostate was significant for \*\*\*. Cystoscopy was performed revealing no tumors, stones or masses. Grade \*\*\* trabeculations were seen. Both ureteral orifices were noted to be in normal anatomic position and of normal character. The laser fiber was then inserted through the sheath and begun at a setting of 80 watts. We began our resection at the 5 o'clock to 7 o'clock position creating a short channel from the bladder neck to just proximal to the verumontanum. The bladder neck was then further taken down. We systematically vaporized tissue along the prostatic urethral floor followed by the left and right lateral lobes. Energy was increased to 120 watts for the lateral lobes. Additional care was taken to minimize resection of the anterior prostate and to avoid the verumontanum and tissue distal to this. We achieved good resection and the prostate was visually open at the conclusion of the case. At this point, we turned our saline irrigation off and assessed for bleeding. There was no significant bleeding noted and, therefore, the procedure nearly concluded. Just prior to removing the scope, we did take another look at the trigone floor, as well as the ureteral orifices and noted that there was no damage to any of these regions. The cystoscope was removed. A \*\*\* Foley catheter was inserted and the balloon was filled with \*\*\* ml of sterile water. The catheter irrigated well. The patient tolerated the procedure well. He was awoken from general anesthesia and transferred to PACU.

I was present and scrubbed throughout the procedure.

Opreimplantopen

DATE OF OPERATION: \*\*\*

PREOPERATIVE DIAGNOSIS: \*\*\*ureter stricture

POSTOPERATIVE DIAGNOSIS: Same

OPERATION:

1. Open \*\*\* ureter reimplant refluxing anastomosis with stent placement

SURGEON:   Nima Baradaran, MD

 Daniel Eiferman, MD

ANESTHESIA:  General.

COMPLICATIONS:  None

ESTIMATED BLOOD LOSS:  100 cc.

DRAINS:  6x\*\*\* ureter stent, JP drain, 16f foley with 10cc in balloon

SPECIMENS:

1. None

FINDINGS:

\*\*\*

INDICATIONS:

This is a @AGE@ y.o. patient with \*\*\*ureter stricture. After discussing her treatment options, she elected to proceed with ureter reimplant. Risks of the procedure was discussed including bleeding, infection, damage to other structures, DVT, anesthesia complications and recurrence of stricture and @HE@ agreed to proceed.

DESCRIPTION OF PROCEDURE:

After appropriate informed consent was obtained, the patient was brought to the operating room.  After induction of general anesthetic, an orogastric tube was placed, and @HE@ was placed in supine position.  At this point, @HE@ was then prepped and draped in standard fashion. All pressure points were well padded.

a Foley catheter was inserted.  An incision was made in the midline below the umbilicus to the pubic bone. Dissection was carried down to subcutaneous tissue until fascia was encountered. Peritoneal cavity was entered with cold scissor. There was minimal adhesions at this point which were released with Dr. Eiferman's assistance.

We then set up our self retractor padding the pressure points on the skin. Her retroperitoneum was expectedly scarred. We medialized the sigmoid colon and entered the retroperitoneum. We identified a tubular structure in the expected location of the left ureter. We obtained circumferential control and passed a vessel loop. We mobilized distally to an obvious area of scar from previous injury. A surgical clip was placed distally and irrigation was injected in the nephrostomy tube \*\*\*which confirmed the ureter. We then transected the ureter with cold scirror and spatulated dorsally.

We then incised the peritoneum and accessed the bladder with minimal mobilization. We filled the bladder and there was excellent volume that would allow a tension free anastomosis with no need for additional maneuvers. We incised the seromuscular layer and the mucosa near the dome on the left. We performed an interrupted anastomosis with 4-0 PDS sutures. We closed the seromuscular layer with 4-0 vicryl. Prior to completion of the anastomosis a sensor wire was placed and a stent was placed in the renal pelvis and the nephrostomy tube was removed.

 We irrigated the abdomen copiously with normal saline and were happy with the hemostasis. We cheecked distal pulses in left leg which were intact on doppler.  We placed a round JP drain in LLQ.

Fascia was closed with looped 0 PDS followed by interrupted subcutaneous vicryl and staples for the skin.  At this point, the procedure was complete.  The patient tolerated the procedure well.

I, Nima Baradaran, MD, was present and performed in the room for the entire procedure.

Opausremovereplace

DATE OF SURGERY: 08/01/19

PREOPERATIVE DIAGNOSIS: Stress urinary incontinence.

POSTOPERATIVE DIAGNOSIS: Stress urinary incontinence.

OPERATION: Removal of all components of defective artificial urinary sphincter.

Placement of artificial urinary sphincter, AMS 800,

cuff size \*\*\* cm, 61-70 cm H2O pressure regulating balloon placed in \*\*\* lower quadrant.

ANESTHESIA: GET

CLINICAL INDICATIONS: The patient is a 61 y.o. man with a

history urinary incontinence and previous AUS. He continues with urinary incontinence and requests a new device. After discussing treatment options, the

patient wishes to proceed with artificial urinary sphincter placement. He understands the risks involved, including infection, erosion, chronic pain, inability of the device to fix his

incontinence, among others, and wishes to proceed.

DESCRIPTION OF PROCEDURE: He was taken to the operating suite,

identified and intubated by the anesthesia team. He was placed in

the lithotomy position with all pressure points well padded. He had bilateral sequential compression devices placed and received periprocedure IV antibiotics per AUA guidelines. An incision was made between the patient's scrotum and anus that was

approximately 3 cm.

Palpating the old cuff, dissection was carried down to the level of the cuff using cautery and cold cut. Cuff was released and using a right angle clamp a measuring tape was placed around the existing location of the cuff. Urethra was healthy with some atrophy. We then delivered the pump through the perineal incision. We then removed the old PRB by \*\*\* making an incision on the old PRB location and removed all components. There was no evidence of infection. The balloon was found to be intact. \*\*\*Wound was copiously irrigated with antibiotic irrigation.

We went back to the cuff. This was then sized to be \*\*\* cm. An incision was used the \*\*\* lower abdominal wall incision. We dissected down

to the level of the fascia, and 2-0 PDS stay stitches were placed and

the fascia incised sharply. A space was created for the reservoir

underneath the fascia. The reservoir was placed and filled with 24.5

mL of sterile normal saline. We then tunneled the pump down into the scrotum on the

patient's right side using blunt dissection with a ring forceps. The tubing was passed. The cuff was then placed around the urethra, and the tubing passed with the trocar to

the abdominal incision. Two connectors were placed and the device

was cycled. We were able to see the device distend. It was locked

in the open position and placed a 12fr foley catheter in the bladder.

The patient's perineal wound was then closed in 3 layers with 4-0 Vicryl and the abdominal wound closed in 2 layers. Skin glue was applied to the abdominal wound. The patient tolerated the procedure well and was transferred to PACU in stable condition.

SURGICAL ATTENDANCE: I, the attending physician, Dr. Nima Baradaran, MD, was present and scrubbed throughout the entire case.

Oproboticreimplant

DATE OF OPERATION: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Right\*\*\* ureter stricture

POSTOPERATIVE DIAGNOSIS: Same

OPERATION:

1. Robotic ureter reimplant with psoas hitch, \*\*\*Right

SURGEON:   @ME@

ANESTHESIA:  General.

COMPLICATIONS:  None.

ESTIMATED BLOOD LOSS:  50 cc.

DRAINS:  6x2\*\*\* ureter stent, JP drain, 16f foley with 10cc in balloon

SPECIMENS:

1. None\*\*\*

FINDINGS:

Evidence of injury from previous surgery distal to iliac vessels. \*\*\*refluxing anastomosis with stent placement. Nephrostomy tube removed at the end of the case.

INDICATIONS:

This is a @AGE@ patient with distal {Right/left:16020} ureter stricture from \*\*\*. After discussing his treatment options, he elected to proceed with ureter reimplant. Risks of the procedure was discussed including bleeding, infection, damage to other structures, DVT, anesthesia complications and recurrence of stricture and @HE@ agreed to proceed.

DESCRIPTION OF PROCEDURE:

After appropriate informed consent was obtained, the patient was brought to the operating room.  After induction of general anesthetic, an orogastric tube was placed, and he was placed in the dorsal lithotomy/supine\*\*\* position.  At this point, @HE@ was then prepped and draped in standard fashion. All pressure points were well padded.

a Foley catheter was inserted. An incision was made in the midline above the umbilicus.  Dissection was carried down to fascia.  A Veress needle was inserted and after confirming its correct location, insufflation was performed.  The needle was removed and an \*\*\*8 mm camera with visiport was placed directly into the abdomen.  At this point, 3 additional robotic ports and a 12 mm assistant port were all placed in standard fashion under laparoscopic visualization.  The patient was placed in the steep Trendelenburg.  The robot was then docked.

We released minimal amount of adhesions around the sigmoid colon. The nephrotomy tube was capped in the holding area in the morning. We identified the right ureter as it was crossing over the iliac vessels. This was dilated with good peristalsis. We incised the peritoneum along the anterior surface of the ureter. We carried the dissection proximally and distally. We left a good amount of adventitia around the around and it was well vascularized. We mobilized posteriorly and passed a vessel loop around the ureter and used this for traction to minimize handling of the ureter. The site of injury was visible and it appeared to be thermal ligation. We dissected the ureter distally with judicious use of bipolar cautery to release the attachments. We then transected the ureter almost mid scar.

At this point we dropped the bladder with com,mbination of electrocautery and blunt dissection. We then decided that she needs a psoas hitch in order to release tension off of our anastomosis. We incised the peritoneum and identified psoas muscle. We identified the genitofemoral nerve and easily avoided it. We placed two 2-0 absorbable sutures in the muscle and tacked the bladder to the right psoas.

We then opened the ureter with sharp dissection dorsally and spatulated it widely. The edges has excellent vascularity and were bleeding briskly. We then made our cystotomy at the dome of the bladder towards the right side. We needed to mobilize the ureter slightly more proximally for a tension free anastomosis. We performed the anastomosis with interrupted 4-0 PDS sutures. Halfway into the anastomosis, We put an angiocatheter through the skin and introduced a sensor wire in the abdomen and placed a 6f x 2\*\*\*xcm double J stent in the ureter. We then completed the anastomosis and did a second layer from bladder seromuscular to ureter adventitia as the extravesical reimplant.

We irrigated the abdomen copiously with normal saline and were happy with the hemostasis. We placed a round JP drain and used Carter Thomson to close the assistant port.

The wounds were copiously irrigated and the skin was closed with a subcuticular stitch. Local anesthetic and Dermabond were applied. At this point, the procedure was complete.  The patient tolerated the procedure well.

I, @ME@, was present and performed in the room for the entire procedure.

Oproboticsimpleprostate

DATE OF OPERATION: 11/07/18

PREOPERATIVE DIAGNOSIS: BPH, bladder stone

POSTOPERATIVE DIAGNOSIS: same

OPERATION:

1. Robotic simple prostatectomy

2. Cystolithotomy

SURGEON: Nima Baradaran, MD

ANESTHESIA:  General.

COMPLICATIONS:  None.

ESTIMATED BLOOD LOSS:  \*\*\* cc.

DRAINS:  A 24-French 3-way Foley catheter (30 cc in balloon). JP drain in LLQ

SPECIMENS:

1. Prostate.

2. Bladder stone

FINDINGS:

\*\*\*

INDICATIONS:

This is a @AGE@ y.o. gentleman who has a history of LUTS secondary to clinical BPH.  He continued to have bothersome symptoms despite medical therapy.  His prostate was measured to be \*\*\* cc.  After discussing his treatment options, he elected to proceed with simple robotic prostatectomy.

DESCRIPTION OF PROCEDURE:

After appropriate informed consent was obtained, the patient was brought to the operating room.  After induction of general anesthetic, an orogastric tube was placed, and he was placed in the dorsal lithotomy position.  A digital rectal exam was repeated and this revealed a large prostate, >100 g.  It was smooth without nodules or induration.  At this point, he was then prepped and draped in standard fashion.

a Foley catheter was inserted.  An incision was made in the midline above the umbilicus.  Dissection was carried down to fascia, and it was grasped with an Allis clamp.  A Veress needle was inserted and after confirming its correct location, insufflation was performed.  The needle was removed and an 12 mm camera  port was placed directly into the abdomen.  At this point, 3 additional robotic ports, 12 mm assistant port and 5 mm assistant port were all placed in standard fashion under laparoscopic visualization.  The patient was placed in the steep Trendelenburg.  The robot was then docked.  A transverse incision was made along the dome of the bladder without dropping the bladder.  This was opened wide enough so that the prostate could be well visualized.  This was a several centimeter incision in the bladder. The bladder was thick and trabeculated. \*\*\* Wetook great care to avoid the ureteral orifices and developed the posterior plane.  At this point, the plane of dissection was continued by myself along the capsule using traction sutures to help get better exposure.  This continued circumferentially.  The urethra was identified and this was carefully transected.  The rest of the attachments were then released and the prostate was now free.

Sutures were placed posteriorly along the bladder neck and anteriorly along the prostatic fossa for hemostasis.  Hemostasis was excellent at this point. A running V-Loc suture was used to approximate the posterior urethra to the posterior bladder neck.  We then gave 5cc of indigo carnine and saw both ureters efflux blue urine. A 24-French Three-way Foley catheter was inserted and inflated to 30 cc.  This did fill the prostatic fossa.  The bladder was then closed with a running 2-0 V-Loc suture.  This was tested and confirmed to be water tight at 240 cc.  At this point, all of the ports were removed under direct vision.  The midline port was extended for specimen extraction after it was placed into a 15 mm entrapment sac.  This was passed off the table and the fascia was closed with four  interrupted 0 vicryl in figure of eight fashion.  The wounds were copiously irrigated and the skin was closed with a subcuticular stitch.  Local anesthetic and Dermabond were applied. At this point, the procedure was terminated.  The patient tolerated the procedure well. I was present in the room for the entire procedure.

Oprpgantegrade

DATE OF PROCEDURE:   @DATE@

PREOPERATIVE DIAGNOSIS: Stricture of {LEFT/RIGHT/BOTH:20078} ureter [N13.5]

POSTOPERATIVE DIAGNOSIS: Stricture of {LEFT/RIGHT/BOTH:20078} ureter [N13.5]

PROCEDURES PREFORMED:

Cystoscopy, {LEFT/RIGHT/BOTH:20078}  retrograde and antegrade pyelogram, {LEFT/RIGHT/BOTH:20078} retrograde pyelogram

SURGEON: Nima Baradaran, MD

ANESTHESIA:  General

FINDINGS:

- \*\*\*

INDICATIONS FOR PROCEDURE:   @AGE@ with history of ureteral injury due to \*\*\* presents today for the aforementioned procedures. @HE@ has a nephrostomy tube.  The risks of the procedure including, but not limited to, pain, bleeding, and infection, were explained to the patient and she elected to proceed. Informed consent was obtained.

PROCEDURE DETAILS: The patient was taken to the operating room and placed supine on the operating table.  Pre-operative antibiotics were administered.  Bilateral lower extremity SCDs were placed.  After induction of general anesthesia the patient was positioned in dorsal lithotomy, prepped and draped in a sterile fashion.  A time-out was performed. Double coverage preop antibiotics were administered.

The rigid cystoscope was passed carefully via the urethra into the bladder and the bladder was completely visualized.  A sensor wire was passed through the {Right/left:16020} ureteral orifice and a 5 French catheter was passed over the wire.  The wire was removed.  A retrograde pyelogram was performed by slowly injecting Omnipaque contrast through the 5 French catheter.  The collecting system was fluoroscopically visualized with findings above.  Contrast was then injected via the indwelling {Right/left:16020} nephrostomy tube for an antegrade nephrostogram with findings as above.

We then filled the bladder to capacity and then drained the bladder into a measuring bowl with findings as above.

The procedure was complete at this point. The patient tolerated the procedure well and was stable throughout.

Nima Baradaran, MD was present in the room the entire duration of the case.

Opscrotoplasty

**@TODAYDATE@**

**Preoperative diagnosis**

Scrotal lymphedema, chronic

**Postoperative diagnosis**

Scrotal lymphedema

\*\*\*

**Procedure performed**

1. Complex scrotoplasty with scrotal advancement flaps (25x20cm)

**Attending surgeon**

Nima Baradaran, MD

**Anesthesia**

General endotracheal anesthesia

30 mL bupivicaine 0.5% local injection

**EBL**

100 mL

**Complications**

None

**Specimen**

1. Scrotum

**Indications**

@AGE@ male with chronic scrotal lymphedema refractory to conservative measures. He requested surgical excision of affected area to decrease the rate of chronic infection and drainage. He agreed to undergo the above named procedure after discussion of the alternatives, risks and benefits. Informed consent was obtained.

**Findings**

1. \*\*\*

**Procedure**

The patient was taken to the operating room and placed supine on the operating table.  Pre-operative antibiotics were administered.  Bilateral lower extremity SCDs were placed.  After induction of general anesthesia the patient was placed into lithotomy position. The patient's genitalia was trimmed, prepped, and draped in a sterile fashion and a time-out was performed.

We began the procedure by marking out a large area of diseased scrotal skin that extended circumferentially around the \*\*\* scrotum. This line was incised with a scalpel and carried this down to the Dartos. The excess skin, as described above, was carefully dissected with both Bovie electrocautery and the LigaSure. Dartos was not violated and testicle was not delivered in the field. Once removed it was sent for pathology. Hemostasis was obtained.

he Dartos was closed with interrupted 3-0 Vicryl suture. Prior to complete closure of the Dartos, JP drain were placed into the hemiscrotum and secured to the skin with 2-0 nylon suture. The remainder of the Dartos was closed. Next, additional 3-0 Vicryl sutures were used to close the skin in a simple interrupted fashion. Additional local anesthesia was given at the incision site. Several retention 2-0 prolene sutures was placed for additional security. Dressing was applied

The patient was awakened, extubated and taken to recovery unit without difficulty. At the end of the procedure all instrument, needle and sponge counts were correct x 2.

Nima Baradaran, MD was present in the procedure room the entire duration of the case.

Opskingraft

Patient

@NAME@

MRN: @MRN@

DOB: @DOB@

DATE OF OPERATION: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: \*\*\*

POSTOPERATIVE DIAGNOSIS: Same

OPERATION:

1. Scrotoplasty with Local advancement flap (cpt 55180)

2. Split-thickness skin harvest from {LEFT/RIGHT/BOTH:20078} thigh

3. Application of Split-Thickness skin graft to \*\*\* (<100 sq cm 15275, >100 sq cm 15277)

FINDINGS:

1. \*\*\*

ANESTHESIA: General

CLINICAL INDICATIONS:The patient is a @AGE@ male with a history of \*\*\* involving his genitalia. After discussing various treatment options, the patient wishes to proceed with cystectomy and ileal conduit. He understands the risks, including bleeding, infection, bowel injury, small bowel obstruction, ureteral stenosis, renal failure, death, among others, and wishes to proceed. Graft risks includes, graft infection, graft loss

PROCEDURE: He was taken to the operative suite, identified and he was intubated by the anesthesia team. He was placed in the low lithotomy position with all pressure points well padded. Both arms were out in anatomic position and padded. Appropriate preoperative antibiotics was administered. Formal time out was performed and he was prepped and draped in normal sterile fashion.

We started with marking the lesion on his scrotum. \*\*\*

We irrigated the wound multiple times with Bacitracin irrigation.

We then turned our attention to graft harvest from {LEFT/RIGHT/BOTH:20078} thigh which was already shaved and prepped into the field. Using Zimmer dermatome on the setting of 0.015 cm we harvested a 10cm x10cm STSG for scrotal reconstruction. We meshed the graft. We secured the graft to underlying tissue using several interrupted absorbable sutures and quilted the graft in place with several more chromic sutures.

For the harvest site we placed a large piece of Telfa soaked in solution that included 10,000 units thrombin and 1:1000 epinephrin mix in saline for hemostasis. We then used a large sheath of Xeroform guaze, bacitracin ointment and mineral oil-soaked cotton bolstered on top of the graft. A 16fr foley catheter was placed at the end of the case with 10cc of sterile water in the balloon. 2x Kerlex and mesh panty was placed over the genital dressing. Burn dressing was applied over the harvest site and wrapped with ACE bandage.

Patient was awakened and transferred to PACU in stable condition

SURGICAL ATTENDANCE: I, the attending physician, Dr. Nima Baradaran, MD, was present and scrubbed throughout the entire case.

Postop care:

Will keep the patient on bedrest for 48 hrs with SQH and SCD for DVT prophylaxis.

Harvest site dressing down in 48 hrs and replace with xeroform gauze and ACE bandage.

Patient will be discharged in 48 hrs with penis dressing and foley in place and follow up in clinic for removal as outpatient.

Opadvancesling

PREOPERATIVE DIAGNOSIS: Urinary incontinence.

POSTOPERATIVE DIAGNOSIS: Urinary incontinence.

OPERATION: Placement of male urethral sling, AMS AdVance.

ANESTHESIA: General endotracheal anesthesia.

CLINICAL INDICATIONS: The patient is a @AGE@ with a history of prostatectomy that resulted in incontinence. He reports mild to moderate incontinence and wishes to proceed with a sling procedure. He understands the risks involved including worsening incontinence, continued incontinence, chronic pain, bleeding, infection, mesh erosion, severe urgency, among other side effects and wishes to proceed.

PROCEDURE: He is taken to the operative suite, identified, and given

Appropriate perioperative antibiotics per AUA guidelines. He was placed in the lithotomy

position with all pressure points well padded. An LMA was placed by

the anesthesia team. An incision was made between the patient's

scrotum and anus. We dissected down and exposed the corpus

spongiosum. We marked where the transverse superficial muscles attached to the bulbar urethra with a 3-0 Vicryl stitch.

We then took down the central tendon to mobilize the urethra sufficiently. With blunt dissection we were able to palpate the pubic arch. We dissected the urethra distally to improve mobilization during sling tightening. We then proceeded with trocar placement. We identified the abductor longus tendon and made a stable incision approximately 1.5 cm inferior to that. A finder needle located the obturator foramina. The trocar was

used and passed just below the pubic arch. The surgeon's hand was dropped perpendicular to the ground to place the needle at the higher point of the arch and the sling was pulled through. The same procedure was performed on the right side. The mesh was then tacked above the previously placed marking stitch with 4 stay stitches.

We then tightened the sling and observed the depression and about 3 cm of movement of the urethra. The arms of the sling were then tunneled medial through the incision.

The wound was closed in 4 layers with 4-0 Vicryl after being irrigated with Bacitracin solution and the incisions were closed with single interrupted 4-0 absorbable suture and skin glue. Prior to the end of the procedure a 12 French Foley was placed to drain the bladder.

I, @ME@ am the attending physician, performed the procedure and was present

throughout.

Opspt

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: \*\*\*

POSTOPERATIVE DIAGNOSIS: Same

OPERATION:

1. Cystoscopy.

2. Intraoperative Ultrasound

3. Percutaneous suprapubic tube placement

ANESTHESIA: General

Findings: \*\*\*

CLINICAL INDICATIONS: The patient is a @AGE@ with \*\*\*.  After discussing treatment options, the patient wished to proceed with placement of SPT. @HE@

understands the risks including infection, bleeding, damage to other structures, bowel injury, pain, among others and wishes to proceed.

PROCEDURE: @HE@ was taken to the operating suite, identified and

intubated by the anesthesia team. A formal timeout was performed and appropriate preoperative dual coverage antibiotic was administrated. He was placed in lithotomy position with all pressure points were well padded.

Cysto showed \*\*\*  Pan cysto did not show any pathology other than catheter irritation. Ureter orifices were in orthotopic position. Bladder was of normal size \*\*\*.

We then performed our ultrasound, there was no overlying structures anterior to the bladder. We made a small incision 2 finger breath above the pubic bone and put him in slight trendelenberg and filled the bladder.

We confirmed placement using a spinal needle and visually inspecting this endoscopically. We then used OneStep kit and placed a 16 french council tip catheter with 10cc in the balloon in the dome of the bladder. There was minimal bleeding and we obtained excellent hemostasis.

Dressing was applied and the patient was awakened and transferred to PACU in stable condition

SURGICAL ATTENDANCE: I, the attending physician, Dr. Nima Baradaran, MD, was present and scrubbed throughout the entire case.

Disposition: Home, they will follow up in 4 weeks for catheter exchange in the office over a wire

Opsptopen

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Rectourethral fistula

POSTOPERATIVE DIAGNOSIS: Same

OPERATION:

1. Exam under anesthesia

2. Cystoscopy.

3. Intraoperative Ultrasound

4. Open suprapubic tube placement

ANESTHESIA: General

Findings: \*\*\*

CLINICAL INDICATIONS: The patient is a @AGE@ man with a \*\*\*. After discussing treatment options, the patient wished to proceed with placement of SPT. He

understands the risks including infection, bleeding, damage to other structures, bowel injury, pain, among others and wishes to proceed.

PROCEDURE: He was taken to the operating suite, identified and

intubated by the anesthesia team. A formal timeout was performed and appropriate preoperative dual coverage antibiotic was administrated. He was placed in low

lithotomy position with all pressure points were well padded.

We started the procedure by doing an examination underanesthesia and cytoscopy. Exam confirmed a 2cm fistual on the rectal side very close and involving the anal sphincter. Cysto showed no anterior strictures, sphincter intact and 2-3cm defect in prostatic urethra on the left. Pan cysto did not show any pathology other than catheter irritation. Ureter orifices were in orthotopic position. Bladder was of normal size.

We then performed ou ultrasound, there was a hollow structure in the subcutaneous tissue that I could not reliably differentiate if it is bowel or not. We placed patient in trendelenburg and filled the bladder but the stricture was unchanged so we decided to perform the surgery with open approach.

We made an infra-umbilical horizontal incision 2 cm above pubic symphysis with 15 blade scalpel. We dissected through anterior sheath and rectus with care not to violate the peritoneal cavity. No bowel was encountered during dissection. We opened the fascia sharply and devided rectus muscle in the midline and identified the bladder. We confirmed this using a spinal needle and visually inspecting this endoscopically. We then placed a guidewire through the spinal needle under direct visualization and dilated the tract to 18 and placed a 16 french council tip catheter over with 10cc in the balloon in the dome of the bladder. There was minimal bleeding and we obtained excellent hemostasis.

Fascia was closed with 2-0 PDS and wound was closed in 3 layers interrupted 2-0 Vicryl sutures. Dressing was applied and the patient was awakened and transferred to PACU in stable condition

SURGICAL ATTENDANCE: I, the attending physician, Dr. @ME@, was present and scrubbed throughout the entire case.

Disposition: Home, they will follow up in 6 weeks for catheter exchange in the office

Turbt

**Preoperative diagnosis**

Bladder tumor

**Postoperative diagnosis**

Bladder tumor

**Procedure performed**

1. Exam under anesthesia

2. Rigid cystoscopy

3. {Right, left-initial cap:1005607} retrograde pyelogram

4. Transurethral resection of bladder tumor, <2cm\*\*\*, 2-5cm\*\*\*, >5cm\*\*\*

5. Fluoroscopy time < 1 hour

**Attending surgeon**

@ATTPROV@

**Anesthesia**

General

**EBL**

10 mL

**Complications**

None

**Specimen**

Urine culture

Left upper tract for cytology

Right upper tract for cytology

Bladder tumor for pathology

\*\*\*

**Findings**

Exam under anesthesia revealed \*\*\*

Cystoscopy revealed a bladder mass \*\*\*.

Left retrograde pyelogram revealed a delicate system with normal caliber ureter with no filling defects. No filling defects with the renal pelvis or calyces. \*\*\*

Right retrograde pyelogram revealed a delicate system with normal caliber ureter with no filling defects. No filling defects with the renal pelvis or calyces. \*\*\*

**Indications**

@AGE@ @SEX@ agreed to undergo the above named procedure after discussion of the alternatives, risks and benefits.

{He/she (caps):30048} was found to have a bladder tumor on cystoscopy for work up of \*\*\* hematuria.

Informed consent was obtained.

**Procedure**

The patient was taken to the operating room and placed supine on the operating table. Pre-operative antibiotics were administered. Bilateral lower extremity SCDs were placed. After induction of general anesthesia the patient was positioned in dorsal lithotomy. A time-out was performed. An exam under anesthesia was performed with the above described findings. The patient was prepped and draped in a sterile fashion.

A 21 French rigid cystoscope was introduced into the bladder under direct vision. \*\*\*A Sensor wire was passed through the {left/right:311354} ureteral orifice and a 5 French catheter was passed over the wire and the wire was removed. A retrograde pyelogram was performed by slowly injecting Omnipaque contrast, 5 mL, through the 5 French catheter. The entire collecting system was fluoroscopically visualized with findings described above. Urine was collected from the upper tract for cytology\*\*\*. The 5 French catheter was then passed through the {left/right:311354} ureteral orifice and the same procedure was performed as described above. The entire collecting system was fluoroscopically visualized with findings above.

Formal rigid cystoscopy was performed next with the aid of the 30 and 70 degree lenses with findings described above.

A 27 French continuous flow resectoscope was introduced into the bladder. Using a working element, the described mass was resected in its entirety. Hemostasis was confirmed. The patient tolerated the procedure well, was awakened, extubated and transferred to the recovery room in stable condition.

@ATTPROV@ was present in the procedure room the entire duration of the case.

Turp

DATE PERFORMED: @TODAYDATE@

PREOPERATIVE DIAGNOSES:  Benign prostatic hypertrophy, lower urinary tract symptoms

POSTOPERATIVE DIAGNOSES:  Same

PROCEDURE:

Transurethral resection of prostate, bipolar

SURGEON:  Nima Baradaran, MD

ANESTHESIA:  General.

ESTIMATED BLOOD LOSS:  minimal

DRAINS:  24F 3-way catheter

SPECIMENS:  Prostate chips

COMPLICATIONS:  None.

POSTOPERATIVE CONDITION:  Stable, extubated to PACU.

INDICATIONS:  This is a 77 y.o. man with a history of BPH and obstructive voiding symptoms. Discussed risks and benefits including bleeding, infection, stricture formation, retrograde ejaculation, ED and anesthesia complications and he is interested to proceed.

DESCRIPTION OF PROCEDURE:  He was informed that residents will be participating in the operation. After explaining all risks, benefits, and

alternatives, and obtaining written informed consent, the patient was

brought to the operating room where he was placed supine on the operating table.  Venodyne boots were placed on the lower extremities, and

the patient received ancef prophylactically.  All appropriate

monitors were placed, and general anesthesia was induced.

He was placed in a dorsal lithotomy position, and the genitals were prepped and draped in a sterile fashion.  A formal timeout was conducted, and the patient was identified by name and medical record number, and procedure was confirmed.  We assembled and lubricated a 26-French bipolar resectoscope with the visual obturator in place and inserted this into the bladder. Urethral evaluation was negative for strictures or lesions. Full cystoscopy was performed which showed trabeculated bladder with trilobar hypertrpphy of the prostate.

We used bipolar electrocautery and resected bilateral lobes of the adenoma with no evidence of capsule involvement. Bladder neck was spared and ureter orifices were marked and avoided. Resection was extended distally to the level of veru. Meticulous hemostasis was obtained. Prostate chips were evacuated and more hemostasis was performed.

The resectoscope was then removed and a 23F 3-way catheter was passed into the bladder with 30cc of water in the balloon. The patient was awoken from general anesthesia. He tolerated the procedure well.

I was present and scrubbed in the room throughout the procedure.

Opuplastybmgdorsal (dorsal onlay bmg)

DATE PERFORMED: @TODAYDATE@

PREOPERATIVE DIAGNOSES:  Benign prostatic hypertrophy, lower urinary tract symptoms

POSTOPERATIVE DIAGNOSES:  Same

PROCEDURE:

Transurethral resection of prostate, bipolar

SURGEON:  Nima Baradaran, MD

ANESTHESIA:  General.

ESTIMATED BLOOD LOSS:  minimal

DRAINS:  24F 3-way catheter

SPECIMENS:  Prostate chips

COMPLICATIONS:  None.

POSTOPERATIVE CONDITION:  Stable, extubated to PACU.

INDICATIONS:  This is a 77 y.o. man with a history of BPH and obstructive voiding symptoms. Discussed risks and benefits including bleeding, infection, stricture formation, retrograde ejaculation, ED and anesthesia complications and he is interested to proceed.

DESCRIPTION OF PROCEDURE:  He was informed that residents will be participating in the operation. After explaining all risks, benefits, and

alternatives, and obtaining written informed consent, the patient was

brought to the operating room where he was placed supine on the operating table.  Venodyne boots were placed on the lower extremities, and

the patient received ancef prophylactically.  All appropriate

monitors were placed, and general anesthesia was induced.

He was placed in a dorsal lithotomy position, and the genitals were prepped and draped in a sterile fashion.  A formal timeout was conducted, and the patient was identified by name and medical record number, and procedure was confirmed.  We assembled and lubricated a 26-French bipolar resectoscope with the visual obturator in place and inserted this into the bladder. Urethral evaluation was negative for strictures or lesions. Full cystoscopy was performed which showed trabeculated bladder with trilobar hypertrpphy of the prostate.

We used bipolar electrocautery and resected bilateral lobes of the adenoma with no evidence of capsule involvement. Bladder neck was spared and ureter orifices were marked and avoided. Resection was extended distally to the level of veru. Meticulous hemostasis was obtained. Prostate chips were evacuated and more hemostasis was performed.

The resectoscope was then removed and a 23F 3-way catheter was passed into the bladder with 30cc of water in the balloon. The patient was awoken from general anesthesia. He tolerated the procedure well.

I was present and scrubbed in the room throughout the procedure.

NBOPUPLASTYBMGFIRSTSTAGE

First stage urethroplasty

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Anterior urethral stricture

POSTOPERATIVE DIAGNOSIS: Anterior urethral stricture

OPERATION:

1. Cystoscopy.

2. Buccal mucosal graft harvest.

3. First tage urethroplasty.

4. Partial urethrectomy.

ANESTHESIA: General

Findings: \*\*\*

CLINICAL INDICATIONS: The patient is a @AGE@ man with a

long history of urethral stricture disease. After discussing treatment

options, the patient wished to proceed with a 2 stage urethroplasty with 4-6 month interval between the stages. He understands the risks including recurrence, sexual dysfunction, chronic pain, and urinary dribbling, among others and wishes to proceed. We also discussed buccal graft harvest and it's complications including damage to salivary duct, pain, change in sensation.

PROCEDURE: He was taken to the operating suite, identified and

intubated by the anesthesia team. A formal timeout was performed and appropriate preoperative antibiotic was administrated. He was placed in supine position with all pressure points were well padded. Methylen blue dye was injected in the urethra for future identification of the lumen. Patient {does/does not:23800} have an SPT in place.

We placed a 2-0 silk glans holding stitch and set up our Lone Star retractor. We made a ventral incision on the penis along the median raphe down to the level of corpora spongiosum. We then opened the urethra ventrally and evaluated the urethral plate. As expected there was no good plate present and we excised the diseased portion of the urethra which was about \*\*\*cm.

We proceeded to perform cystoscopy through the urethrotomy. It demonstrated no further strictures proximally, prostate was found to be \*\*\*, bladder neck was \*\*\*. Bladder was found to have {MILD/MODERATE/SEVERE:20080} trabeculations with no evidence of any lesions or stones. The distance from external sphincter to the proximal edge of our urethrotomy was \*\*\*cm.

We then harvested a buccal mucosal graft from {LEFT/RIGHT/BOTH:20078} side of the cheek. Prior to harvest we identified and marked the Stensen duct. We then proceeded to harvest our graft, starting our dissection approximately 5 mm from the vermilion line of the lip extending back to harvest a 2 x 4 cm graft. This was defatted on the back table. The mouth was closed in a Z-plasty technique with interrupted 4-0 chromic stitched.

We sutured the proximal end of the buccal graft to the distal edge of the existing urethral mucosa with interrupted 4-0 Vicryl sutures. We used 4-0 chromic stitches to quilt and tack the graft over the corpora cavernosa. We then secured the edges of the graft to surrounding corporal tissue and the meatus distally with excellent hemostasis. We left 3 long stitches on either side of the graft in order to secure our dressing in place. We placed a large piece of xeroform gauze followed by a small bulk of mineral oil soaked gauze over the graft and tied the stiches to secure the graft in place.We then placed a 16fr foley catheter in the bladder with 10cc of sterile water in the balloon. We then gently wrapped the penis in xeroform and coban dressing.

The patient tolerated the procedure well, was awakened and transferred to PACU in stable condition.

SURGICAL ATTENDANCE: I, the attending physician, Dr. @ME@, was present and scrubbed throughout the entire case.

NBOPUPLASTYBMGVENTRAL – ventral onlay bmg

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Anterior urethral stricture

POSTOPERATIVE DIAGNOSIS: Anterior urethral stricture

OPERATION:

1. Cystoscopy.

2. Buccal mucosal graft harvest.

3. \*\*\* cm ventral onlay one-stage urethroplasty.

ANESTHESIA: General

Findings: \*\*\*

CLINICAL INDICATIONS: The patient is a @AGE@ man with a

long history of urethral stricture disease. After discussing treatment

options, the patient wished to proceed with urethroplasty. He

understands the risks including recurrence, sexual dysfunction,

chronic pain, and urinary dribbling, among others and wishes to

Proceed. We also discussed buccal graft harvest and it's complications including damage to salivary duct, pain, change in sensation.

PROCEDURE: He was taken to the operating suite, identified and

intubated by the anesthesia team. A formal timeout was performed and appropriate preoperative antibiotic was administrated. He was placed in high

lithotomy position with all pressure points were well padded. Methylen blue dye was injected in the urethra for future identification of the lumen. Patient {does/does not:23800} have an SPT in place.

An incision was made from the patient's scrotum down to 2 cm above his anus. We

dissected down to the corpora spongiosum with a combination of cold dissection and electrocautery. We then used a 20 red rubber to identify where the urethral stricture is and marked this with surgical pen. We appreciated

it at the \*\*\* bulbar urethra. We then made an incision on the ventral aspect of corpora spongiosum until visualized the urthral mucosa which is blue from previous Methylen blue injection. The stricture was opened along its length using scissors and measured and was found to be approximately \*\*\* cm. We then mobilized the urethra about 1cm proximally and distally.

We proceeded to perform cystoscopy through the urethrotomy. It demonstrated no further strictures proximally, prostate was found to be \*\*\*, bladder neck was \*\*\*. Bladder was found to have {MILD/MODERATE/SEVERE:20080} trabeculations with no evidence of any lesions or stones. The distance from external sphincter to the proximal edge of our urethrotomy was \*\*\*cm.

We decided to perform an augmentation urethroplasty using buccal graft and harvested a buccal mucosal graft from {LEFT/RIGHT/BOTH:20078} side of the cheek.

Prior to harvest we identified and marked the Stensen duct. We then proceeded to

harvest our graft, starting our dissection approximately 5 mm from the vermilion line of the lip extending back to harvest a 2 x 4 cm graft. This was defatted on the back table. The mouth was closed in a Z-plasty technique with interrupted 4-0 chromic stitched. The graft was tapered into the shape of an ellipse, and 3 apical stitches were

placed to begin the anastomosis distally and then proximally. A running anastomosis was performed with 4-0 PDS on the inner layer medially and then an outside lateral layer. It should be noted that all sites were mucosa to mucosa. Prior to completion of the anastomosis a 16fr foley was placed in the bladder with 10cc of sterile water in the balloon. The corpus spongiosum was then closed with running 4-0 PDS. The wound was washed out, a 1/4 inch penrose drain was left, and the wound was closed in 4 layers.

The patient tolerated the procedure well, was awakened and transferred to PACU in stable condition.

SURGICAL ATTENDANCE: I, the attending physician, Dr. @ME@, was present and scrubbed throughout the entire case.

Opuplastyepa – epa

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Anterior urethral stricture

POSTOPERATIVE DIAGNOSIS: Anterior urethral stricture

OPERATIONS:

1. Cystourethroscopy.

2. Partial urethrectomy.

3. Anastomotic urethroplasty.

FINDINGS:

\*\*\*

ANESTHESIA: General

CLINICAL INDICATIONS: @AGE@ male with urethral stricture disease who presents for urethroplasty. \*\*\*. After discussion of risks and benefits of urethroplasty not limited to bleeding, infection, stricture recurrence, sexual dysfunction, ejaculatory dysfunction, post void dribbling, urinary incontinence, and pain, he wishes to proceed.

PROCEDURE:

The patient was put under general anesthesia, formal time out was performed and perioperative antibiotics were administered. A suprapubic tube {HAS HAS NOT:19958} been placed prior to reconstruction. He The lower, genitalia, and perineum were prepped and draped in a sterile fashion after the patient was placed in high lithotomy position with all pressure points well padded. 10cc of Methylene blue was instilled in the urethra for future identification of the lumen. A midline perineal incision was made.This was extended down through the subcutaneous tissues and the bulbocavernous muscle was divided using combination of electrocautery and sharp dissection. The urethra and

corpus spongiosum were freed from the underlying tunica albuginea and perineal body.

A 20 French Robinson catheter was placed to the level of the stricture and marked with surgical pen. At the distal aspect of the stricture the urethra was transected and the stricture was completely removed. Calibration of the proximal and distal ends of the transected urethra to 24 French was performed using bougies. The proximal urethra was spatulated dorsally and the proximal stump was spatulated ventrally for about 1cm in either direction.

Cystoscopy was then performed and demonstrated \*\*\* the proximal urethra to be free of stricture disease. There were no stones or lesions in the visualized portion of the bladder \*\*\*. Prostate was \*\*\*. There was \*\*\*cm distance between the proximal end of the incision to the external sphincter.

The urethra was then mobilized until a tension free anastomosis could be performed. The anastomosis was begun by approximating the dorsal aspect of the epithelium with interrupted 5-0 PDS sutures. These sutures approximated both the epithelium and the spongiosum on the dorsal wall. As this anastomosis was carried toward the perineal surface a two layer closure of the ventral urethra was performed. The inner layer of urethral epithelium was reapproximated with interrupted 5-0 PDS sutures. A 16 French urethral catheter was inserted through and across the area of reconstruction and into the bladder prior to completion of anastomosis of the inner layer. Next, approximation of the ventral corpus spongiosum was performed using interrupted 5-0 PDS sutures. The wound was irrigated and hemostasis was achieved. A standard 4 layer closure was performed with interrupted 4-0 vicryl sutures. A 0.25 inch Penrose drain was left in place. Sterile dressing was placed, he was moved out of lithotomy and transferred to PACU in stable condition.

SURGICAL ATTENDANCE: I, the attending physician, Dr. @ME@, performed the procedure and was there throughout.

Opuplastyfemalebmg

Female urethroplasty with BMG

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Anterior urethral stricture

POSTOPERATIVE DIAGNOSIS: Anterior urethral stricture

OPERATION:

1. Cystoscopy.

2. Buccal mucosal graft harvest.

3. \*\*\* cm dorsal onlay one-stage female urethroplasty.

ANESTHESIA: General

Findings: 3cm stricture in mid urethra extending to proximal urethra. Buccal harvest from left cheek.

CLINICAL INDICATIONS: The patient is a @AGE@ y.o. female with a

long history of urethral stricture disease. After discussing treatment

options, the patient wished to proceed with urethroplasty. She

understands the risks including recurrence, sexual dysfunction,

chronic pain, and urinary dribbling, among others and wishes to

Proceed. We also discussed buccal graft harvest and it's complications including damage to salivary duct, pain, change in sensation.

PROCEDURE: She was taken to the operating suite, identified and

intubated by the anesthesia team. A formal timeout was performed and appropriate preoperative antibiotic was administrated. She was placed in high

lithotomy position with all pressure points were well padded. Patient does not have an SPT in place.

Retraction sutures was placed in labia minora and majora for exposure. Stricture would barely accommodate a 5f open ended catheter. We placed a wire in the urethral. W emade a semi circular incision above the urethra and developed the plane between corporal body of the clitoris and urethra below the pubic bone. We extended the dissection dorsally until we felt we have passed the stricture area. We then incised urethra longitudinally until the stricture was opened. We needed to dissect the urethra more proximally to achieve healthy proximal urethra.

We proceeded to perform cystoscopy through the urethrotomy. It demonstrated no further strictures proximally, bladder neck was normal. Bladder was found to have mild trabeculations with no evidence of any lesions or stones. The distance from external sphincter to the proximal edge of our urethrotomy was 1cm.

We decided to perform an augmentation urethroplasty using buccal graft and harvested a buccal mucosal graft from the left side of the cheek.

Prior to harvest we identified and marked the Stensen duct. We then proceeded to

harvest our graft, starting our dissection approximately 5 mm from the vermilion line of the lip extending back to harvest a 2 x 4 cm graft. This was defatted on the back table. The mouth was closed in a Z-plasty technique with interrupted 4-0 chromic stitched. The graft was tapered into the shape of an ellipse, and 3 apical stitches were

placed to begin the anastomosis distally and then proximally. Several 5-0 chromic was used to tack the posterior aspect of the graft to the corpora cavernosum. A running anastomosis was performed on the inner layer medially and then an outside lateral layer. It should be noted that not all sites were mucosa to mucosa. A final 16-French Foley catheter was left in place prior to completion of the anastomosis. Vaginal edges was closed using 4-0 figure of 8 interrupted sutures. Vaginal packing was placed. The wound was washed out.

The patient tolerated the procedure well, was awakened and transferred to PACU in stable condition.

SURGICAL ATTENDANCE: I, the attending physician, Dr. Nima Baradaran, MD, was present and scrubbed throughout the entire case.

NBOPUPLASTYNONTRANSECTING

Non transecting anterior urethroplasty

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Anterior urethral stricture

POSTOPERATIVE DIAGNOSIS: Anterior urethral stricture

OPERATIONS:

1. Cystourethroscopy.

2. One stage urethroplasty (non-transecting approach).

FINDINGS:

\*\*\*

ANESTHESIA: General

CLINICAL INDICATIONS: @AGE@ male with urethral stricture disease who presents for urethroplasty. \*\*\*. After discussion of risks and benefits of urethroplasty not limited to bleeding, infection, stricture recurrence, sexual dysfunction, ejaculatory dysfunction, post void dribbling, urinary incontinence, and pain, he wishes to proceed.

PROCEDURE: He was taken to the operating suite, identified and

intubated by the anesthesia team. A formal timeout was performed and appropriate preoperative antibiotic was administrated. He was placed in high

lithotomy position with all pressure points were well padded. Methylen blue dye was injected in the urethra for future identification of the lumen. Patient {does/does not:23800} have an SPT in place.

An incision was made from the patient's scrotum down to 2 cm above his anus. We

dissected down to the corpora spongiosum with a combination of cold dissection and electrocautery. We then used a 20 red rubber to identify where the urethral stricture is and marked this with surgical pen. We appreciated it at the \*\*\* bulbar urethra. We then dissected around the corpora spongiosum proximally and distally and lifted the urethra off the corporal cavernosum with Metzenbaum scissor. An incision was made on the dorsal surface of the corpora spongiosum, and the stricture was opened and measured and was found to be approximately \*\*\* cm. He was found to have good urethral plate with no significant spongiofibrosis and we decided to perform a non-transecting urethroplasty. We then mobilized the urethra distally to the penoscrotal junction and 1-2cm proximally towards membranous urethra.

At this point we proceeded to perform cystoscopy through the existing urethrotomy. It demonstrated no further strictures proximally, prostate was found to be \*\*\*, bladder neck was \*\*\*. Bladder was found to have {MILD/MODERATE/SEVERE:20080} trabeculations with no evidence of any lesions or stones. The distance from external sphincter to the proximal edge of our urethrotomy was \*\*\*cm.

We then performed a Heineke-Mikulicz type approach with 10 interrupted

5-00 PDS on the back wall of the corpora spongiosum including the urethral mucosa using tagged shods numbered 1 through 10 to aid our tying. Prior to tying the sutures we passed a final 16f foley catheter with 10cc of sterile water in the balloon. We then tied the sutures and this provided excellent coaptation with good hemostasis. We applied hemostatic mesh on dorsal aspect of the corpora spongiosum over the corpora cavernosum to assist with hemostasis.

The wound was washed out with antibiotic solution, a 1/4 inch penrose drain was left, and the wound was closed in 4 layers.

The patient tolerated the procedure well, was awakened and transferred to PACU in stable condition.

SURGICAL ATTENDANCE: I, the attending physician, Dr. @ME@, was present and scrubbed throughout the entire case.

Nbopuplastyposteriorbulbsparing

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Complex posterior urethral stricture

POSTOPERATIVE DIAGNOSIS: Complex posterior urethral stricture

OPERATION:

1. Cystoscopy.

2. Complex posterior urethroplasty, bulbar sparing approach.

3. Partial prostatectomy.

ANESTHESIA: General

Findings: \*\*\*

CLINICAL INDICATIONS: The patient is a @AGE@ man with a

long history of urethral stricture disease. After discussing all treatment options, the patient wished to proceed with posterior urethroplasty. He understands the risks including recurrence, sexual dysfunction, chronic pain, and urinary dribbling, among others and wishes to proceed. I specifically discussed with him the risk of urinary incontinence which will require future placement of an artificial urinary sphincter if it occurs, I quoted 5% - 20% risk based on severity of stricture, his other comorbid conditions and degree of involvement of external sphincter. An informed consent was obtained.

PROCEDURE: He was taken to the operating suite, identified and

intubated by the anesthesia team. A formal timeout was performed and appropriate preoperative antibiotic was administrated. He was placed in high

lithotomy position with all pressure points were well padded. Methylen blue dye was injected in the urethra for future identification of the lumen. Patient {does/does not:23800} have an SPT in place.

An incision was made from the patient's scrotum down to 2 cm above his anus. We

dissected down to the corpora spongiosum with a combination of cold dissection and electrocautery. We then used a 20 red rubber to identify where the urethral stricture is and marked this with surgical pen. We appreciated it at the membranous/proximal bulbar urethra.

We then dissected around the corpora spongiosum proximally and distally and lifted the urethra off the corporal cavernosum with Metzenbaum scissor. 2 vessell loops were used to assist visualization and retraction of the urethra. We decided that he {Needs / does not need:13302} corporal splitting to create more space to work and provide a tension free anastomosis. We then incised the proximal bulbar urethra dorsally in order to evaluate the urethral plate. There was significant involvement of the plate but the ventral corporal spongiosum was soft and healthy. We decided to perform a bulbar-sparing approach and preserve {LEFT/RIGHT/BOTH:20078} bulbar arteries. We excised the diseased portion of the urethra and did a partial prostatectomy until patulous and healthy urethral mucosa was identified accommodating a 22fr bougie easily. We then mobilized the urethra distally to the level of penoscrotal junction to provide a tension-free anastomosis.

At this point we proceeded to perform cystoscopy through the existing urethrotomy. It demonstrated no further strictures proximally, prostate was found to be \*\*\*, bladder neck was \*\*\*. Bladder was found to have {MILD/MODERATE/SEVERE:20080} trabeculations with no evidence of any lesions or stones. The distance from external sphincter to the proximal edge of our urethrotomy was \*\*\*cm.

We then performed the anastomosis in the usual fashion with 7 stitches of double-armed 5-0 PDS around the clock face using tagged shods numbered 1 through 7 to aid our tying. Prior to tying the sutures we passed a final 16f foley catheter with 10cc of sterile water in the balloon. We then tied the sutures and this provided excellent coaptation with good hemostasis. We applied hemostatic surgical mesh on dorsal aspect of the corpora spongiosum over the corpora cavernosum to assist with hemostasis.

The wound was washed out with antibiotic solution, a 1/4 inch penrose drain was left, and the wound was closed in 4 layers.

The patient tolerated the procedure well, was awakened and transferred to PACU in stable condition.

SURGICAL ATTENDANCE: I, the attending physician, Dr. @ME@, was present and scrubbed throughout the entire case.

Nbopuplastyposteriortransect

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Complex posterior urethral stricture

POSTOPERATIVE DIAGNOSIS: Complex posterior urethral stricture

OPERATION:

1. Cystoscopy.

2. Complex posterior urethroplasty.

3. Partial prostatectomy.

ANESTHESIA: General

Findings: \*\*\*

CLINICAL INDICATIONS: The patient is a @AGE@ man with a

long history of urethral stricture disease. After discussing all treatment options, the patient wished to proceed with posterior urethroplasty. He understands the risks including recurrence, sexual dysfunction, chronic pain, and urinary dribbling, among others and wishes to proceed. I specifically discussed with him the risk of urinary incontinence which will require future placement of an artificial urinary sphincter if it occurs, I quoted 5% - 20% risk based on severity of stricture, his other comorbid conditions and degree of involvement of external sphincter. An informed consent was obtained.

PROCEDURE: He was taken to the operating suite, identified and

intubated by the anesthesia team. A formal timeout was performed and appropriate preoperative antibiotic was administrated. He was placed in high

lithotomy position with all pressure points were well padded. Methylen blue dye was injected in the urethra for future identification of the lumen. Patient {does/does not:23800} have an SPT in place.

An incision was made from the patient's scrotum down to 2 cm above his anus. We

dissected down to the corpora spongiosum with a combination of cold dissection and electrocautery. We then used a 20 red rubber to identify where the urethral stricture is and marked this with surgical pen. We appreciated it at the membranous/proximal bulbar urethra.

We then dissected around the corpora spongiosum proximally and distally and lifted the urethra off the corporal cavernosum with Metzenbaum scissor. 2 vessell loops were used to assist visualization and retraction of the urethra. We decided that he {Needs / does not need:13302} corporal splitting to create more space to work and provide a tension free anastomosis. We then incised the proximal bulbar urethra dorsally in order to evaluate the urethral plate. There was significant involvement of the plate as well as severe spongiofibrosis making the plate unfavorable for a bulbar-sparing approach. Therefore we made a plane between the bulbar urethra and the rectal fat using Metzenbaum scissor and continued the dissection to the level of the membranous urethra. We preserved {LEFT-RIGHT-NA:20207} bulbar arteries along this process. The urethra was then transected using Metzenbaum scissor and packed using a moist sponge away from the field.

We {WERE/WERE NOT:19886} able to easily identify the proximal urethral stump. We {Actions; did/ did not:19250} use antegrade cystoscopy to assist with identification of proximal urethral stump. We {Actions; did/ did not:19250} use antegrade Gelman sound through the suprapubic tract to assist with identification of proximal urethral stump. We excised about \*\*\* cm portion of prostate and membranous urethra, performing the partial prostatectomy until we reached patulous and healthy urethral mucosa accommodating a 22fr bougie easily.

At this point we proceeded to perform cystoscopy through the existing urethrotomy. It demonstrated no further strictures proximally, prostate was found to be \*\*\*, bladder neck was \*\*\*. Bladder was found to have {MILD/MODERATE/SEVERE:20080} trabeculations with no evidence of any lesions or stones. The distance from external sphincter to the proximal edge of our urethrotomy was \*\*\*cm.

We brought the distal urethra back into the field and continued the dissection to the penoscrotal junction until the gap was easily bridged in a tension-free manner. We {Actions; did/ did not:19250} require pubectomy in this process. The proximal urethra was spatulated dorsally and the proximal stump was spatulated ventrally for about 1cm in either direction. We then performed our anastomosis in the usual fashion with 10 stitches of double-armed 5-0 PDS around the clock face using tagged shods numbered 1 through 10 to aid our tying. Prior to tying the sutures we passed a final 16f foley catheter with 10cc of sterile water in the balloon. We then tied the sutures and this provided excellent coaptation with good hemostasis. We applied hemostatic surgical mesh on dorsal aspect of the corpora spongiosum over the corpora cavernosum to assist with hemostasis.

The wound was washed out with antibiotic solution, a 1/4 inch penrose drain was left, and the wound was closed in 4 layers.

The patient tolerated the procedure well, was awakened and transferred to PACU in stable condition.

SURGICAL ATTENDANCE: I, the attending physician, Dr. @ME@, was present and scrubbed throughout the entire case.

Opuplastysecondstage

DATE OF SURGERY: @TODAYDATE@

PREOPERATIVE DIAGNOSIS: Anterior urethral stricture

POSTOPERATIVE DIAGNOSIS: Anterior urethral stricture

OPERATIONS:

1. Cystourethroscopy.

2. Urethroplasty, second stage tubularization of urethral plate, neomeatus creation

3. Dartos flap harvest for second layer coverage

FINDINGS:

\*\*\*

ANESTHESIA: General

CLINICAL INDICATIONS: @AGE@ male with urethral stricture disease who has had a first stage urethroplasty in the past using buccal mucosal graft and is here today for a planned second stage urethroplasty. After discussion of risks and benefits of this step which is not limited to bleeding, infection, stricture recurrence, sexual dysfunction, ejaculatory dysfunction, post void dribbling, urinary incontinence, and pain, he wishes to proceed. I specifically discussed with him the risk of fistula formation which will require repair in the future if it occurs.

PROCEDURE:

The patient was put under general anesthesia and was placed supine on the table. Formal time out was performed and perioperative antibiotics were administered.The genitalia was prepped with Betadine and draped in a sterile fashion. His urethral plate was wide with excellent graft take from previous stage. We placed a 2-0 silk glans holding stitch and a 14 fr foley without issue. We then marked around the open urethra and onto the glans to make small glans wings. We used a microknife to incise along our marked incisions. Scissors were used to dissect around the urethral plate such that it was free and able to be tubularized easily around the foley catheter. We then re-approximated the cut edges of the urethral plate with a running sub-cuticular style 4-0 PDS up to the proximal glans.

We then harvested a 2x4cm rotational flap of dartos and brought it over the suture line and tacked it in place with 4-0 Vicryl sutures to protect our repair. We then placed several 4-0 vicryl interrupted stitches at the distal portion of our urethroplasty to the glans skin to mature the neomeatus. We closed the glans wings in 2 layers with excellent hemostasis. Skin was closed with simple interrupted 4-0 vicryls.

Bacitracin was applied to skin, then xeroform over our incision. The penis was wrapped with a 4x4 gauze and then a coban dressing. He was awakened and transferred to PACU in stable condition.

SURGICAL ATTENDANCE: I, the attending physician, Dr. @ME@, performed the procedure and was there throughout.

Pelvicpain

I explained to the patient that pelvic pain requires multi-modal therapy. I have advised the patient to undergo the following:

Pelvic physical therapy.

I gave the patient a referralpelvic physical therapy. This will help teach him exercises that may relieve his pain

Stress reduction

The patient should reduce external/internal stress. This stress will worsen his chronic pain.

Exercise

The patient exercises daily he should continue to do so

Interstitial cystitis/pelvic pain diet

We discussed the interstitial cystitis diet. There many foods that can cause bladder pain including spicy foods, citrus, red wine. I would like the patient toconsider what foods make his pain worse in to think about what he ate in the last 48 hours when he has a flare.

Posterioruplasty disc

We discussed the risks and benefits of posterior urethroplasty including the risks of infection; bleeding (5% chance of transfusion); recurrent stricture (5% at five years, 10% at 10 years, with good durable long-term response); the 50% response rate to postoperative recurrent stricture with DVIU; the risk of erectile dysfunction (largely related to the injury, 30-60% long term complete ED); urinary incontinence (unlikely, usually related to recognized bladder neck injury, neurogenic dysfunction of the bladder neck, and not due to the loss of sphincteric function, which is an established and accepted risk of this injury and its surgical correction). We discussed other complications including lower extremity complications (5%, usually limited to short term numbness or pain lasting 24-48 hours, rarely severe requiring intervention for compartmental syndrome (1/500 cases) and general complications of surgery. We discussed the need for pubectomy in a small subset of men, the need for cystotomy in a small subset of men, but the fact that the vast majority of men can undergo re-establishment of continuity with only a single incision in the perineum. We discussed the length of procedure (4-5 hours), the expected hospitalization (less than 24 hours), the duration of catheterization (three weeks), and the possibility of extravasation on the postop VCUG (requiring another one to two weeks of catheterization). The patient understands all these risks and wished to proceed with surgery. I answered all his questions and he signed the informed consent.

Perc spt

We used ultrasound with the abdominal probe and filled the bladder with normal saline. There was no interposing bowel identified. We placed a spinal needle in the bladder and a guidewire through the needle. We incised the skin for 2 cm and dilated the tract and inserted the introducing sheath under direct cystoscopic visualization. We then placed a 16f council tip foley catheter and inflated the balloon and removed the sheath and placed a purse string stitch using 2-0 nylon to the skin and around the catheter. Urine was clear and catheter was attached to the bag.

Postvoiddrib

I would like the patient to do 3 things to help prevent postvoid dribbling:

1. He should apply pressure to his perineum behind his scrotum and lift forward to help expel urine retained in the bulbar urethra

2. He should shake his penis to remove any residual drops

3. He should use tissue to blot the tip of his penis to assure no leakage.

Preophighrisk

@HE@ understands that this is considered a high risk procedure. I told @HIM@ that @HIS@ prior abdominal operations\*\*\*, history of radiation\*\*\* and \*\*\* makes this surgery complex. We discussed surgical technique and hospital course. We reviewed postop recovery including possible need for rehab.

We specifically talked about risks including infection, bleeding, need for blood transfusion, damage to surrounding structures including bowel and major vessels, anesthesia complications, pneumonia, DVT, pulmonary embolism and even possible death. I gave no guarantees for success.

After a long conversation @HE@ asked excellent questions and I answered them all to the best of my ability.@HE@ demonstrated good understanding of the process and is willing to proceed with surgery.

Rug/vcug

Preoperative diagnosis: Lower urinary tract symptoms and possible urethral stricture

Postoperative diagnosis: \*\*\*

Procedure: Retrograde urethrogram, voiding cystourethrogram, catheterization, fluoroscopic interpretation

Findings:\*\*\*

Clinical indication: \*\*\* with symptoms suggestive of urethral stricture plan for retrograde urethrogram and voiding cystourethrogram to delineate stricture for surgical planning. Risks benefits and alternatives discussed with the patient including but not limited to infection and bleeding.

Procedure: The patient was taken to the operative suite identified and placed in the lateral decubitus position with his left leg straight and his right leg bent. The penis was placed on stretch. With the aid of a catheter and gauze proximally 10 mL of radiocontrast full-strength was administered into the patient's anterior urethra. \*\*\*. We then turned our attention to performing a voiding cystourethrogram. An 8 French feeding tube was passed into the patient's bladder. The bladder was filled with radiocontrast until the patient felt the need to urinate.\*\*\*.

Plan: \*\*\*

Sptchangefluoro

The patient was taken back to the procedural suite and placed in a supine position. He was prepped and draped in a standard sterile fashion. A sensor was was introduced through his exisiting supra pubic tube. Fluoroscopy was used to confirm appropriate confirmation and wire location. The foley was then withdrawn over the wire. A \*\*\* fr council tip foley catheter was then advanced over the until return of urine was seen. Placement was confirmed with injection of 50cc contrast for a cystogram under fluro. The wire was removed and the balloon was inflated. The foley was hooked up to a drainage bag at the end of the procedure.

Uroflow/pvr

Procedure: Complex uroflow study

His voided volume was \*\*\* mL and his peak flow was \*\*\*mL/sec. His voiding time was \*\*\* sec. His average flowrate was \*\*\*. His overall voiding pattern was \*\*\*.

Procedure: Bladder ultrasound postvoid residual

The patient was positioned in the supine position. The ultrasound machine was placed on the patient's lower abdominal region 2 fingerbreadths above the pubic bone. The bladder which postvoid residual was \*\*\* mL.

Bekpcnl

I discussed the options with the patient We discussed the options of watchful waiting, ureteroscopy, shock wave lithotripsy, and percutaneous nephrolithotomy including the risks, benefits, and alternatives. The patient was told of there is a risk of bleeding, pain, infection, and adjacent organ injury with the procedure. I told them that if @HE@ had persistent bleeding that did not stop @HE@ may require a renal angiogram and angio-embolization. The patient was told that they could develop numbess, tingling, or muscle-weakness near the incision site. A second-look procedure may be performed if there are residual stone fragments. @CAPHE@ was given the opportunity to ask any questions, these were answered, and informed consent was obtained for a {Left/right:33004} percutaneous nephrolithotomy.

Bekpcnlminileft

Date of Procedure: <\*\*\*>

Procedure Performed: Cystoscopy, Left Retrograde Pyelogram, Left Supine Mini PCNL, Left Retrograde Stent Placement

Surgeon: Bodo Knudsen, MD, FRCSC

Assistant: <\*\*\*>

Anesthesia General

Preoperative diagnosis: Left Renal Stone > 2.0 cm

Postoperative diagnosis: Left Renal Stone > 2.0 cm

Preamble:

Patient is a very pleasant gentleman with a large 2+cm left sided kidney stone. A decision was made to proceed with a left PCNL in the supine position.

Procedure:

Patient was taken to the OR and administered a general anesthetic. He was positioned for a left supine PCNL and right leg placed in lithotomy. He was prepped and drape.

The flexible cystoscopy was passed via the urethra and a hybrid guidewire advanced to the kidney. A 5F catheter was placed as was a Foley catheter.

A left sided retrograde pyelogram through the 5F catheter reveal a mildly dilated left kidney with a massive filling defect occupying the pelvis and lower pole consistent with the known stone.

Using a combination of ultrasound and fluoroscopic guidance, the left lower pole was punctured with a 18F needle. A hybrid wire was advanced into the collecting system and down the ureter to the bladder. An 8-10 dilator was used to place a second wire, a superstiff.

The tract was dilated with a 16.5F one step dilator and the 17.5F sheath placed. The stone was encountered and broken up and cleared with the Shockpulse lithotripter. Inspection with fluoroscopy and flexible nephroscopy revealed no obvious residual stones.

A decision was made to place a stent. In a retrograde fashion a <\*\*\*>cm x 7F stent was placed with the tether left on. The upper end was confirmed in the upper pole and the lower end curled in the bladder.

The Foley catheter was replaced. The sheath removed under direct vision with no evidence of adjacent organ injury and minimal bleeding. 10cc of Marcaine with epinephrine were injected and skin closed with Biosyn and Dermabond glue.

The procedure was complete. There were no complications of note. The patient was transferred to recovery in stable condition.

Bekpcnlsupineleft24

Date of Procedure: <\*\*\*>

Procedure Performed: Cystoscopy, Left Retrograde Pyelogram, Left Supine 24F PCNL, Left Retrograde Stent Placement

Surgeon: Bodo Knudsen, MD, FRCSC

Assistant: <\*\*\*>

Anesthesia General

Preoperative diagnosis: Left Renal Stone > 2.0 cm

Postoperative diagnosis: Left Renal Stone > 2.0 cm

Preamble:

Patient is a very pleasant gentleman with a large 2+cm left sided kidney stone. A decision was made to proceed with a left PCNL in the supine position.

Procedure:

Patient was taken to the OR and administered a general anesthetic. He was positioned for a left supine PCNL and right leg placed in lithotomy. He was prepped and drape.

The flexible cystoscopy was passed via the urethra and a hybrid guidewire advanced to the kidney. A 5F catheter was placed as was a Foley catheter.

A left sided retrograde pyelogram through the 5F catheter reveal a mildly dilated left kidney with a massive filling defect occupying the pelvis and lower pole consistent with the known stone.

Using a combination of ultrasound and fluoroscopic guidance, the left lower pole was punctured with a 18F needle. A hybrid wire was advanced into the collecting system and down the ureter to the bladder. An 8-10 dilator was used to place a second wire, a superstiff.

The tract was dilated with a 24F balloon and the sheath placed. The stone was encountered and broken up and cleared with the Shockpulse lithotripter. Inspection with fluoroscopy and flexible nephroscopy revealed no obvious residual stones.

A decision was made to place a stent. In a retrograde fashion a <\*\*\*>cm x 7F stent was placed with the tether left on. The upper end was confirmed in the upper pole and the lower end curled in the bladder.

The Foley catheter was replaced. The sheath removed under direct vision with no evidence of adjacent organ injury and minimal bleeding. 10cc of Marcaine with epinephrine were injected and skin closed with Biosyn and Dermabond glue.

The procedure was complete. There were no complications of note. The patient was transferred to recovery in stable condition.

Stentpcnlbilateralremoval

PROCEDURE PERFORMED   
   
Cystoscopy with bilateral double J stent removal.   
   
SURGEON   
   
Bodo E Knudsen, MD. Dr. Knudsen was present and participated in the entire procedure

PROCEDURE NOTE   
   
The patient is status post bilateral PCNL and returns today for stent removal as part of a planned staged procedure. After explain the risks of bleeding, pain and infection, an informed consent was obtained.

After being prepped and draped the flexible scope was passed via the urethra into the bladder and the distal end of the stent was visualized, captured and entirely removed.

The scope was passed a second time and the contralateral stent was removed intact without difficulty.

The patient tolerated the procedure well and there were no difficulties with it.

Stentpull

PROCEDURE PERFORMED   
   
Cystoscopy with {Right/left:16020} double J stent removal.   
   
SURGEON   
   
Bodo E Knudsen, MD. Dr. Knudsen was present and participated in the entire procedure

PROCEDURE NOTE   
   
The patient is status post ureteroscopy and returns today for stent removal. After explain the risks of bleeding, pain and infection, an informed consent was obtained.

After being prepped and draped the flexible scope was passed via the urethra into the bladder and the distal end of the stent was visualized, captured and entirely removed.

The patient tolerated the procedure well and there were no difficulties with it.

Bekuricacid

I am starting you on maximal medical therapy to try and dissolve your uric acid kidney stones. Please take the Potassium citrate at a dose of 2 tablets three times a day. Also take the Allopurinol 300mg once a day. If you develop a rash with the Allopurinol, please stop it and notify my office. The rash can become dangerous if you continue the Allopurinol.

Please work hard on your fluid intake. Please drink at least 8 glasses of fluid a day. Diluted orange juice and water are best.

Beekudsnote

**Preprocedure diagnosis**

\*\*

**Postprocedure diagnosis**

\*\*

**Procedure**

1.  Cystometrogram, complex

2.  Uroflowmetry, complex

3.  EMG of anal sphincter

4.  PVR

**Attending surgeon**

Bodo E Knudsen, MD

**Anesthesia**

None

**Complications**

None

**Indications**

\*\*is a \*\* y.o. male with history above

He presents today for urodynamics.

We discussed the risks and benefits of the procedure including the risks of hematuria and infection.

**Operative summary**

The patient was prepped and draped in a standard sterile fashion.  A catheter was placed with a 7 french double-lumen urodynamic catherter.  A rectal baloon pressure transducer was placed in an atraumatic fashion.  An EMG electrode was placed at 3 and 9:00 of the peri-anal region.

**Current related medications**

No                                        Anticholinergics

No                                        Alpha-blockers

**Filling cystometry**

50mL/min                                                              Fill rate

200mL                                                                             First sensation

300mL                                                                             Strong desire

500mL                                                                             Imminent void/maximum cystometric capacity

17 cm of water                                            End filling pressure

No                                                                                    Uninhibited detrusor contraction

No                                                                                    Incontinence with valsalva

**Voiding cystometry**

At maximum capacity the patient then voided.

\*\* ml/s                                                                 Qave

\*\* ml/s                                                                 Qmax

\*\* cm of water                                            Pdet at Qmax

\*\* ml                                                                               Voided volume

The voiding curve \*\*

The A-G nomogram was \*\* (obstructed, non obstructed)

**Post-Void Residual**

A post-void residual was \*\* mL

**Impression**

Storage Phase

Normal                                 bladder capacity

Normal                                 bladder compliance

No                                        detrusor contractions (uninhibited)

No                                        detrusor overactivity incontinence

No                                        stress urinary incontinence

Voiding Phase

Abnormal / reduced              detrusor activity (contractility)

Normal                                 sphincter synergy

No                                        bladder outlet obstruction

Bakcalciumdiscussion

In terms of calcium replacement, I recommend you follow up with your family doctor to discuss a bone density study. If the bone density is low, then it would be appropriate to start a calcium supplement. We recommend calcium citrate (eg. CitraCal) which should be taken with meals. If the bone density in normal or high, then likely a calcium supplement is not needed. However, please discuss this with your family physician.

Bekcallappt

If you start to get severe left back pain, the stone might be passing. Please either go to the emergency department (ask for a copy of any xrays that they do) or call my office (614-293-9349) and come in for an appointment.

Bekcystinediet

Cystinuria Diet (https://sites.google.com/site/cystinuriauk/diet-tell-me-more)

**Increasing fluid in the diet**  
  
What should I drink? All liquids count toward your fluid targets. Some people prefer to avoid tea, coffee and alcohol as these can dehydrate you. However, it is best to drink anything in moderation as long as the bulk of its content is a fluid such as water, which does not dehydrate you.   
  
**Tips to help you increase your fluid intake:**

1. Drink a large glass of water at specific times during the day e.g. when you get up in the morning, when you arrive at work, after using the toilet etc.
2. Enjoy a glass of fruit juice with your breakfast.
3. Keep a large bottle or mug of water at your desk and sip from it throughout the day.
4. Try drinking through a straw, it may help you drink more.
5. Drink one glass of water each hour on the hour.
6. When you have a craving for a snack, drink a glass of water, squash or a fizzy drink (choose diet if you are watching your weight) instead.
7. Add slices of lemon, lime or oranges to cool water. This gives it a pleasant flavour and helps to alkalinise your urine.
8. Drink two full glasses of fluid at each meal – one before and one after eating.
9. Carry a refillable water bottle everywhere – walking, shopping, driving, watching television, doing laundry, etc.
10. Flavour your water with squash.
11. Eat more fruits and vegetables as they contain a high amount of water.
12. Include liquid and moist foods in your diet e.g. soups, stew, jellies etc.

**Fluid content of moist food:**

1. 150g Pot yoghurt - 120ml
2. 100g Fromage frais - 80ml
3. 150g Rice pudding/ custard -  120ml
4. Porridge (medium size) - 130ml
5. 1 scoop ice cream - 60ml
6. 1 small ice lolly - 50ml
7. 1 large ice lolly - 130ml
8. 1 tablespoon sauce/ gravy - 20ml

**Reducing your salt intake**  
  
It has been shown in some small studies that salt restriction reduces cystine excretion in both adults and children. The mechanism behind this is not known. (Goldfarb, Coe & Asplin, 2006). A high salt intake is directly associated with significant increase in renal calcium excretion and can therefore also increase the risk of calcium based stone formation, (Straub & Hautmann 2005). Cystinuria patients are at risk of forming calcium based stones so it is worth noting this.   
Reducing salt intake has numerous other health benefits. It helps prevent raised blood pressure and reduces the risk of the following health problems:

1. Stroke
2. Heart attacks and heart failure
3. Osteoporosis
4. Stomach cancer
5. Kidney disease ([www.actiononsalt.org.uk](http://www.actiononsalt.org.uk/) 2010)

**Tips to lower your salt intake**

1. Stop adding salt to your food during cooking.
2. Avoid adding salt to your meal at the table – taste it first and add other flavourings such as herbs, spices, mustard, pepper, lemon juice, garlic, and vinegar instead if you wish.
3. Cut down on the amount of salty ingredients used in cooking such as stock cubes, soy sauce, garlic salt or celery salt. Look out for low salt stock cubes or powders to use instead or make your own.
4. Avoid obviously salty foods such as crisps, nuts and salted biscuits.
5. Cook with fresh foods as often as possible rather than relying on ready made or processed foods.
6. Increase the amount of fruit and vegetables in your diet and use fresh or frozen vegetables rather than tinned vegetables.

* Check food labels and try to choose brands that contain less salt.
* Look out for reduced salt varieties of some processed food e.g. baked beans, pickles, ready meals.
* Choose breakfast cereals that are low in salt or contain no added salt such as Shredded Wheat, Weetabix or porridge.
* Avoid packet or tinned soups. Try homemade soup instead.

**Reducing methionine in your diet**

**Error! Hyperlink reference not valid.**Reducing your intake of animal protein foods such as meat, fish and cheese will mean you have less methionine (the amino acid precursor to cystine) in your diet. Less methionine in the diet will mean there is less cystine being filtered and excreted via the kidney. A reduced methionine diet has been recommended for patients based on this premise. (Barbey et al. 2000; www.emedicine.com 2007). It is worth noting that even if all dietary amino acid intake is eliminated, cystine will still be produced in the body by normal metabolic activity (Mattoo & Goldfarb, 2008).   
  
Protein is a very important nutrient in the body. One of its functions is growth and repair in the body so it is important that you eat enough to meet your body’s needs. When you decrease your intake of animal protein you should try to increase your intake of vegetable protein foods such as beans and pulses. Protein is also found in smaller amounts in other foods such as bread, potatoes and pasta.  
  
The amount of protein you need depends on your weight. Your Dietitian can help you work out how much protein you need.  
  
**Alkalinisation of the Urine**  
  
Alkalinisation of the urine can help prevent the formation of cystine stones. The solubility of cystine in the urine is 250mg/L up to a pH level of 7.0, but solubility of cystine increases to 500mg/L or more with a pH level of 7.5 (Mattoo & Goldfarb, 2008). A urine pH of greater than 7.5 can predispose to the formation of calcium phosphate stones, therefore it is important to monitor urine pH level and try to maintain between 7- 7.5.  
  
Drinking alkalinizing beverages, such as mineral water, rich in bicarbonate and low in sodium (1500mg bicarbonate/L, maximum 500mg sodium/L) and citrus juices may be helpful.

Reduction of animal protein, which is the major dietary source of protons, reduces renal proton excretion and increases urine pH. A reduction in animal protein intake often leads to an increase in fruit and vegetable consumption. Fruit and vegetables are high in organic anions which will help to alkalinise the urine by reducing renal proton excretion and increasing bicarbonate in the urine (Mattoo & Goldfarb 2008).   
  
**Why is a healthy weight important?**  
Overweight people are at a significant increased risk of stone formation. Urine pH is unfavourably low, in terms of crystallisation risk, in overweight patients (Straub & Hautmann, 2005). It has been found that people with a higher body mass index (BMI) have higher urinary excretions of uric acid, sodium, phosphate and ammonium (Siener R et al. 2004). Thus, overweight people have an increased risk of forming a variety of kidney stone types.

Overweight and obese people are at increased risk of the following conditions:-

* Type 2 diabetes
* Cardiovascular disease
* Dyslipidaemia
* Hypertension
* Osteoarthritis
* Breathlessness
* Hyperuricaemia and gout
* Certain cancers; including colon, kidney, prostate (men), postmenopausal breast and endometrial (Thomas 2007)

**Why is eating enough fibre important?**

A wide variety of high-fibre plant foods contain a compound called phytate. It has been demonstrated in experimental studies that patients with a low phytate intake had an increased risk of calcium oxalate stone formation (Straub and Hautmann 2005). As cystine stone formers are also at an increased risk of forming other stone types, it would be wise to ensure an adequate fibre intake.

**Why is having enough calcium in my diet important?**

As most of us know, calcium is important for bone health. Adequate calcium intake is also important in helping prevent formation of kidney stones. It has been found in two large studies that reduced calcium intake resulted in increased formation of calcium stones (Tiselius et al., 2002). As cystine stone formers can also develop calcium based stones it is important to ensure adequate calcium intake.  
  
  
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www.emedicine.com Biyani, C.S.(2007) Cystinuria. Accessed July 2008.

**Error! Hyperlink reference not valid.**

http://www.emedicine.com/MED/topic498.htm

dietoxalate

Please review the handout I gave you regarding oxalate containing foods. By limiting your intake of foods high in oxalate, you may decrease your stone risk by lower the oxalate concentration in the urine.

Eswl disc

We discussed the risks benefits and alternatives for treatment of the stone. We discussed the options of watchful waiting versus ureteroscopy and laser lithotripsy versus shock wave lithotripsy. The patient preferred shockwave lithotrispy {With-without:5700} stent insertion. @CAPHE@ was informed the risks of bleeding, pain and infection. @CAPHE@ was told there was a 1-2% risk of a perinephric hematoma and a possibility of obstruction from stone fragments. The patient was also told that the stone might not fragment or it may require repeat treatment. @CAPHE@ was explained the inherent risks of anesthesia. @CAPHE@ was told that if a ureteral stent is placed, it would likely result in urinary frequency, urgency, and dysuria, as well as flank pain with voiding. The stent would be removed at a later date as an office based procedure. The patient was given the opportunity to ask any questions and after answering @HIS@ questions and an informed consent was obtained.

Eswl note

Date: {date}

Surgeon: Bodo Knudsen

Assistants: { }

Procedure: { } ESWL

Preoperative Diagnosis: { } Kidney stone

Postoperative Diagnosis: Same

Procedure:

Patient was taken to the procedure room for ESWL. The { } stone was targeted with fluoroscopy. A total of 2500 shocks were delivered using cardiac gating. The first 500 shocks were delivered at lower energy and a pause and protect protocol was utilized. A maximum energy of {5} was reached.

The patient tolerated the procedure well and was stable throughout. The patient will follow up in 2 weeks with a KUB xray.

J Urol. 2011 Jan;185(1):192-7. Epub 2010 Nov 13.

**Multi-institutional assessment of ureteroscopic laser papillotomy for chronic flank pain associated with papillary calcifications.**

[Gdor Y](file:///C:\pubmed%3fterm=%22Gdor%20Y%22%5bAuthor%5d), [Faddegon S](file:///C:\pubmed%3fterm=%22Faddegon%20S%22%5bAuthor%5d), [Krambeck AE](file:///C:\pubmed%3fterm=%22Krambeck%20AE%22%5bAuthor%5d), [Roberts WW](file:///C:\pubmed%3fterm=%22Roberts%20WW%22%5bAuthor%5d), [Faerber GJ](file:///C:\pubmed%3fterm=%22Faerber%20GJ%22%5bAuthor%5d), [Teichman JM](file:///C:\pubmed%3fterm=%22Teichman%20JM%22%5bAuthor%5d), [Lingeman JE](file:///C:\pubmed%3fterm=%22Lingeman%20JE%22%5bAuthor%5d), [Wolf JS Jr](file:///C:\pubmed%3fterm=%22Wolf%20JS%20Jr%22%5bAuthor%5d).

**Source**

Department of Urology, University of Michigan, Ann Arbor, Michigan, USA.

**Abstract**

**PURPOSE:**

We evaluated the long-term safety, efficacy and durability of ureteroscopic laser papillotomy for chronic flank pain associated with renal papillary calcifications.

**MATERIALS AND METHODS:**

We reviewed the medical records of all patients who underwent ureteroscopic laser papillotomy in the absence of free urinary calculi at our institutions from 1998 through 2008. Success was defined as patient report of significant pain relief. The duration of response was considered the time from papillotomy to repeat papillotomy in the same renal unit, patient report of recurrent pain or final followup.

**RESULTS:**

Ureteroscopic Ho:YAG laser papillotomy was done a total of 176 times in 65 patients, including 147 unilateral and 29 bilateral procedures. Of the patients 39 underwent multiple procedures (2 to 12). Symptomatic followup was available in 50 patients (146 procedures) during a mean of 38 months. Significantly less pain was reported after 121 procedures (83%). The mean duration of response per procedure was 26 months and 30 patients (60%) had a mean remission duration of greater than 1 year. Postoperatively hospital admission was required after 14 procedures (8%). There was no significant change in the mean estimated glomerular filtration rate during a mean 41.3-month followup. Seven of the 65 patients (11%) had hypertension before papillotomy. In 3 of the 49 patients (6.1%) with adequate followup new hypertension developed during a mean of 38 months.

**CONCLUSIONS:**

Ureteroscopic laser papillotomy is safe and effective. In patients with papillary calcifications and characteristic chronic, noncolicky pain this procedure provides significant, moderately durable symptom relief.

Bekurs

We discussed the risks benefits and alternatives for treatment of the stone. We discussed the options of watchful waiting versus ureteroscopy and laser lithotripsy versus shock wave lithotripsy. The patient preferred ureteroscopy and laser lithotripsy with possible stent insertion. @CAPHE@ was informed the risks of bleeding, pain and infection as well as ureteral injury. @CAPHE@ was explained the inherent risks of anesthesia. @CAPHE@ was told that if a ureteral stent is placed, it would likely result in urinary frequency, urgency, and dysuria, as well as flank pain with voiding. The stent would be removed at a later date as an office based procedure. The patient was given the opportunity to ask any questions and after answering @HIS@ questions and an informed consent was obtained.

Bekursconsent

We discussed the treatment options for the {Location; L/R/Bilat:18416} stone including ureteroscopy and laser lithotripsy and ESWL. After explaining the risks, benefits, and alternatives a decision was made to proceed with right ureteroscopy and laser lithotripsy. The patient was explained the specific risks of bleeding, pain, infection, and ureteral injury. In addition, the patient was told he may need a stent placed. The stent could result in urinary frequency, urgency, dysuria, and flank pain with voiding. It would require an office based procedure to remove it at a later date. Finally, the patient was told if the stone was very impacted, that we would place a stent and return at a later date to treat the stone. An informed consent was obtained for a {Location; L/R/Bilat:18416} ureteroscopy with laser lithotripsy, possible stent placement.

Bekursinstructions

Please follow up next Wednesday with Dr. Knudsen in the office. You have two stents in place. They will be removed next Wednesday.

It is normal to have blood in the urine with the stents. Please drink plenty of fluids and go to the bathroom regularly.

If you have high fevers please contact the office or go to an emergency department to be assessed.