the degree of incurvation, the concomitant presence or not of erectile dysfunction, etc. If the length of the penis is normal, with preserved sexual potency, and the deformity is mild or moderate (less than 50º), the Nesbit technique or plicature of the tunica albuginea suffices to correct the deformity and secure a functional penis. In contrast, in patients with large plaques, marked curvatures (over 50º), hourglass deformity, a short penis, distal flaccidity, or failure of previous surgery, plaque incision or excision is indicated, associated to the placement of a graft with or without penile prosthesis implantation — this approach being reserved for patients with erectile dysfunction unresponsive to medical therapy[4,5]. Many tissues of different origins have been used to correct the defect of the tunica albuginea after Peyronie plaque incision / excision, though no ideal material has yet been found. At present, the grafts can be classified as follows: a) autologous grafts (fascia lata, fascia temporalis, Buck fascia, tunica vaginalis, saphenous vein, dermis, dorsal rectus fascia, oral mucosa, etc.), which are the most widely used; b) heterologous grafts (porcine small bowel submucosa, bovine pericardium, etc.); and c) synthetic materials (Dacron®, Dexon®, Goretex®, etc.). The current tendency is to avoid the latter materials due to their antigenicity and inadequate functional properties[6,7]. The characteristics required of an ideal graft are histological similarity to the tunica albuginea, scant antigenicity, and resistance and elasticity to support erections. In addition, the graft must be easy to obtain and should be available in large sizes[6], since it is important for the graft to have at least 30% more surface than the defect to be covered, or else graft contraction will lead to repeat incurvation after surgery. The anterior rectus fascia exhibits the desired characteristics. On the other hand, the medical literature published to date, with long-term results, reports excellent clinical performance after using this graft[6,8,9]. In our case, on the basis of the existing reviews, and considering that we needed a graft size of approximately 5 × 3 cm, we chose an anterior rectus fascia graft.

Although most authors presently do not recommend complete removal of the plaque but only its incision - since full resection would require a large patch, which implies an increased risk of retraction, veno-occlusive failure and loss of erectile function — we consider it to be a good treatment option in selected cases. Regarding the anterior rectus fascia, we consider that it meets the criteria of an ideal graft, since it is morphologically and structurally similar to the tunica albuginea, and affords large patches, with scant added morbidity.

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Urethral prolapse in postmenopausical women

Prolapso de mucosa uretral en mujer posmenopáusica

Dear Editor,

Urethral prolapses are considered to be relatively infrequent. The are seen in two different age groups: prepuberal girls and postmenopausal women.

We present the case of a 74-year-old woman with a history of arterial hypertension and atrial fibrillation treated with Sintrom®. The patient reported to the emergency room of our hospital due to genital bleeding for the past few days. There were no micturition alterations. Exploration revealed

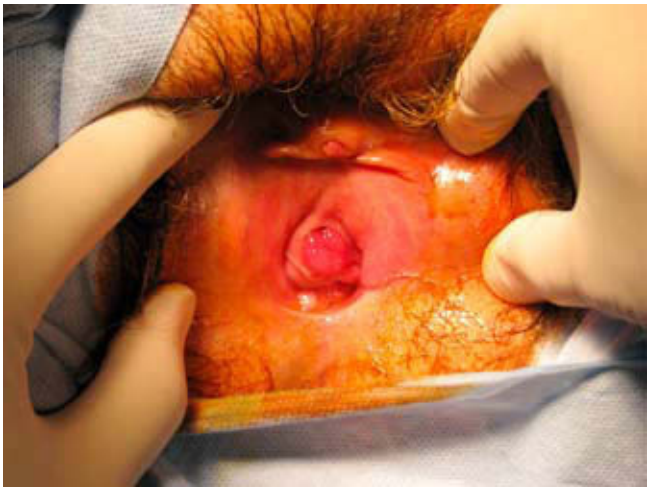

Figure 1 – Collapsed urethral mucosa.

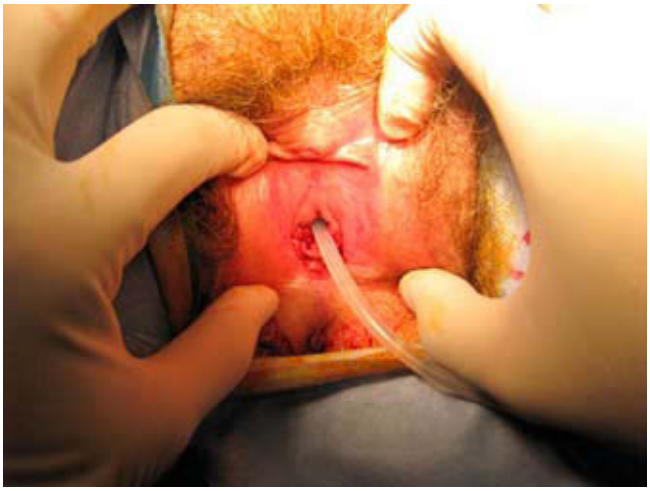

Figure 2 – Urethral meatus after the operation.

a prolapsed mucosal portion (measuring about 2 cm) at the urethral meatus, that bled in response to friction. The patient reported mild discomfort in response to palpation, and pressure was able to partially reduce the prolapse. With the diagnosis of urethral mucosa prolapse, discharge was decided with topical and local application of hydrogen peroxide and corticoid cream. After three months of treatment, the prolapse had improved, decreasing in size and without further bleeding. However, the patient continued to suffer great difficulty sitting, with intense pain in response to friction, and she rejected the conservative management provided. Exeresis of the prolapsed mucosa was thus performed under local anesthesia (figs. 1 and 2) and on a major ambulatory surgical basis with bladder catheterization for three days. Three months after the operation, the patient is free of symptoms.

Female urethral mucosa prolapse comprises a circular eversion of the urethral mucosa, which protrudes around the meatus. The underlying etiology and physiopathology are not clear. The condition may be congenital or acquired, since it has been reported both in women of advanced age and in prepuberal girls[1-3]. Congenital prolapses are a consequence of an excessively redundant urethral mucosa secondary to a defect of the supporting collagen tissue at submucosal level. This situation in turn would induce hypermobility of the mucosal layer and would give rise to prolapse[4]. Acquired prolapses have been related to a range of triggering factors such as sharp increments in abdominal pressure[11] (due to loss of adherence between the internal longitudinal and external circular smooth muscle layers), recurrent urinary infections, abdominopelvic traumatisms, burns, malnutrition, estrogen deficits (postmenopausal women, oophorectomy, following chemotherapy) or sexual abuses[4].

The clinical picture usually varies according to the age of the patient. In prepuberal girls urinary symptoms are usually absent and vaginal bleeding tends to be common — leading the patient to seek medical help. In contrast, in postmenopausal women it is much more common to observe dysuria, urge and increased micturition frequency, together with possible urinary retention[1,8] (large prolapses causing mucosal strangulation) and dyspareunia. In cases of thrombosis and necrosis, urethral bleeding and local pain are the predominant manifestations[9,12].

The diagnosis is usually based on the clinical findings, though differentiation is required with respect to disorders such as urethral caruncle, bladder prolapse, urethral diverticuli, ureterocele prolapse or even tumors[5,7,10].

Physical examination reveals a fleshy and discretely edematous lesion with a central orifice (unlike urethral caruncle, in which the orifice is located in the upper zone). Some authors recommend cystoscopy for differentiation with respect to prolapsed ureterocele[4]. In addition, histological evaluation of the resected mucosa is recommended in order to rule out malignancy.

Treatment is usually conservative in the form of sitting baths, estrogen creams and manual reduction of the prolapse[6]. If these measures prove ineffective, or in the case of incarcerated or large prolapses, surgical removal of the prolapsed mucosa is advised, followed by suturing of the healthy mucosa to the urethral margin - generally with good postoperative results. Other described management options are ligation over an urethral catheter, electrocoagulation and cryosurgery[5,11,13].

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A simple technique for testicular implant insertion and size election: A case report

Una técnica sencilla para el implante testicular con adecuada elección del tamaño: reporte de un caso

Dear Editor,

The lack of a testicle is not only a psychological problem but also a physical or aesthetic concern for patients. This explains the increasing demand for procedures offering improved aesthetic results in which not only the defect is repaired but the evidence of surgery is moreover occulted[1].

In a study of patients subjected to orchiectomy due to testicle cancer, 27% of those interviewed and who carried a testicular prosthesis claimed to be satisfied with its placement, while 37% were not satisfied with the size of the implant, and one-third of the patients were not offered the possibility of an implant[2].

We present a simple testicle implant technique involving adequate selection of the size of the prosthesis, offering good aesthetic results and patient satisfaction.

The present case corresponds to a 27-year-old patient with prior right-side orchiectomy performed in adolescence due to a lack of testicle descent. After antibiotic treatment, a mid-scrotal line was marked, and a suprascrotal incision was made. The incision was infiltrated with 0.25% bupivacaine with adrenalin 1:200,000. A 2-cm suprascrotal incision was made, and the scrotum was accessed through blunt dissection. For correct placement and choice of the size of the prosthesis, a Foley 16F catheter was inserted in the scrotum (fig. 1). The catheter balloon was gradually filled to a volume of 32 ml, which was when the size was found to be similar to that of the contralateral testicle. Following correct placement of the catheter, and after having measured the size of the implant, immediate scrotal tissue expansion was carried out, filling the balloon to 40 ml. The prosthesis was submerged in cefazolin, and the catheter was removed after collapsing the balloon. The surgeons changed gloves and washed them with cefazolin, and likewise painted the incision with povidone iodine. The prosthesis was then inserted and affixed to the

Figure 1 – A Foley 16F catheter was inserted in the scrotum for correct placement and measurement of the size of the prosthesis.