

PEDIATRIC UROLOGY

Passerini-Glazel feminizing genitoplasty: modifications in 17 years of experience with 82 cases.

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Objectives: To describe modifications of Passerini-Glazel feminizing genitoplasty and report on long-term functional outcome.

Methods: Modifications include vaginal dissection and disconnection from the urethrovaginal sinus as the initial stage of the procedure; large dissection of the neurovascular bundle on both dorsal and lateral faces of the clitoris; plication of the skin around the reduced clitoris; and suturing the lateral edge of the proximal portion of the mucocutaneous plate with the labia majora's medial edge to a plane deeper than the subcutaneous tissue. These modifications reduce bleeding and operating time, better preserve clitoral sensitivity, form the clitoral prepuce, and create labia minora.

Results: Eighty-two patients underwent modified Passerini-Glazel feminizing genitoplasty. Mean operating time was 120min (range: 100-180). Forty-six patients (46 of 82, 56%) were assessed at a mean follow-up of 5 yr (range: 2-9). There were no cases of clitoral vascularization defect or urethrovaginal fistula. The urethral meatus was never hypospadiac. The vaginal introitus was large and elastic in all cases. Vaginal caliber at the internal suture line was as large as the vaginal introitus and the distal native vagina in 20 (43.5%) of the 46 girls. All mothers and patients reported satisfaction with external genital appearance.

Conclusions: These long-term results suggest that our modifications of one-stage Passerini-Glazel feminizing genitoplasty facilitate the procedure and produce good cosmetic results.

Editorial Comment

In this manuscript, consecutive cases from 1988-2005 were reviewed. 82 primary cases were done by the Passerini-Glazel feminizing genitoplasty technique with some modifications. There were 22 remaining cases that had undergone surgery elsewhere and the primary cases were operated in an average age of two years while the secondary cases were operated at an average age of 13 years. The manuscript has a good description of the procedure and excellent diagrams for those who might be less familiar with the procedure. Complication rates of the procedures seem acceptable and the long-term follow up that was done. 56% of the patients underwent general anesthesia months to years after surgery showing good results.

Modifications of the procedures recommended by the authors were:

1. to dissect the urogenital sinus from the vagina first before it is separated from the corporal cavernosal bodies
2. complete removal of the corporal spongiosum minimizes bleeding and operating time
3. it is important to separate the posterior vaginal wall from the inferior urethral wall for a length of about 1 cm, which allows mobilization of the native urethra and avoids vaginal stenosis
4. to reduce vaginal stenosis at the suture line they recommend aggressive removal of the distal dysplastic segment of the vagina
5. make a U-shaped inverted skin flap in the perineum to rotate in and become part of the vaginal exterior suture line
6. make incisions in the corporal cavernosal bodies at 3 and 9 o'clock to minimize neurovascular bundle compromise
7. if the glans clitoris needs to be reduced they recommend a wedge from the ventral midline rather than two lateral triangles as was originally described

This procedure is helpful in difficult urogenital sinus cases and this manuscript and its illustration will be beneficial to surgeons who undertake these procedures.

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Lymphatic-sparing laparoscopic varicocelelectomy versus microscopic varicocelelectomy: is there a difference?

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Objectives: The ideal operation for the adolescent varicoceles has been debated for many years as new techniques or advances in existing technology develop. It is well acknowledged that the Palomo procedure has a negligible recurrence rate but a very high postoperative hydrocele rate compared with a microscopic varicocelelectomy (MV). We sought to determine whether lymphatic-sparing laparoscopic varicocelelectomy (LSLV) could provide similar negligible recurrence rates as the Palomo approach with the negligible postoperative hydrocele rate seen with MV.

Methods: We performed a retrospective chart review of patients who underwent either an MV (n = 31) or LSLV (n = 28). In the MV group, the artery and the lymphatics were spared, whereas in the LSLV group, the artery and veins were taken en masse. Statistical analysis included paired Student t-test and Chi-square test for continuous and categorical variables, respectively.

Results: Preoperative testis volumes were not different nor were the postoperative testis volumes between groups. Mean operating time was significantly longer in the MV than the LSLV group (140 minutes versus 51 minutes, P <0.01). With a mean time since surgery of 2 years, we observed only one patient with a recurrent varicocele (MV group); only one patient developed a hydrocele requiring hydrocelelectomy (LSLV group).

Conclusions: Our early data indicate that LSLV and MV are comparable in preventing varicocele recurrence and formation of hydroceles. The primary difference between the procedures is the surgical time, with the LSLV being much faster to perform.

Editorial Comment

This study is a comparison between 31 patients with a microscopic varicocelectomy technique in 28 patients with a lymphatic-sparing laparoscopic varicocele technique over a 28-month period. Indications for the surgery were either pain or testicular hypotrophy defined as a 20% volume difference between testicles. Postoperative checks were at one week, six months and every 6-12 months thereafter. Testicular ultrasounds were encouraged postoperatively. Age and grade of varicoceles and bilateralism were not statistically significant between the groups. There were no immediate postoperative complications. There were no testis volume differences postoperatively on the 64% of patients who had ultrasounds and the left testis volume increased postoperatively in both groups. Only one recurrent varicocele was seen in the microscopic group and none in the laparoscopic group. There was one patient in the laparoscopic group who developed a hydrocele postoperatively that has subsequently been repaired.

Several techniques reported in the literature correct varicoceles. The microscopic technique has had the lowest varicocele recurrence and hydrocele development rates. This study shows that a laparoscopic lymphatic-sparing technique has as good of results as the microscopic group. It is good to know that the laparoscopic technique can have similar success rates and the major advantage of the laparoscopic technique in the study is shorter operating times by an hour-and-one-half. It may be that in the future laparoscopic techniques may be more familiar to urologists than the microscopic techniques, but only time will tell.

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