What is NEW in Soft Tissue Surgery?

New surgical approach for laryngeal paralysis

Laryngeal paralysis makes life difficult for many senior Labradors and their owners, especially during the summer months. Wheezing/stridor, change in voice, exercise intolerance, and respiratory distress are all symptoms, yet the traditional surgical technique (unilateral cricoarytenoid lateralization) can also be troublesome.

Concerns about these postoperative risks may soon be a thing of the past. Dr. Fitzwater, during her surgical training at The Ohio State University, learned a new surgical approach for cricoarytenoid lateralization to treat this condition and has begun using it here. ***Compared to the accepted published technique, this new procedure reduces the risk of aspiration pneumonia following surgery by 20%.*** Developed by a resident mate of hers, the details will remain proprietary until it is released for publication.

Patients who undergo this procedure typically remain in the hospital overnight for observation and can be released the following day if recovering without complication.

Artificial urethral sphincters

Urinary incontinence secondary to urethral sphincter mechanism incompetency (USMI) continues to remain a concern for post-ovariohysterectomy females and ectopic ureter dogs following surgical correction. Even though medical management with phenylpropanolamine and estrogen hormone therapy has helped tremendously, many patients continue to leak.

Submucosal urethral implants (collagen or polytetrafluoroethylene) via cystoscopy are often less favorable due to implant availability, a risk of decrease in the intraluminal diameter, and the potential for rejection. Other surgical procedures like sling urethroplasty, cystourethropexy, and colposuspension have often led to poor long-term results.

Placement of a *hydraulic urethral occluder* is a new technique that is proving to be beneficial. ***The initial work shows 100% restoration of the continence that remained for over two years.***
This is a silicone vascular occluder that is placed of equal circumference to the pelvic urethra around the proximal urethra. The device is primed with saline and is attached to tubing that exits the abdominal wall, tunneled subcutaneously, and is connected to a saline primed infusion port that is anchored to the underlying tissue. This infusion port allows the occluder to be filled with saline which applies pressure to the proximal urethra. The occluders are initially placed empty and it has been found that some do not need to be filled at all.

Potential complications of this technique can include implant infection, urinary obstruction, or leakage of fluid from the device and reoccurrence of the incontinence.

If you have patients who might benefit from either of these new techniques, contact Dr. Fitzwater for more information.