



Supplemental Figure 1 Surgical procedure. In this trial, all patients underwent surgery under epidural anaesthesia or spinal anaesthesia. The patient was prepared and draped, while supine with the scrotum exposed and prophylactic antibiotics were administered. An incision approximately 3–4 cm long was made at the level of the groin or on the scrotum through the previous orchiectomy incision, although we preferred the inguinal approach. A tunnel was created through which the testicular prosthesis could be placed; this step was especially important when the implantation procedure did not closely follow the orchiectomy. When the incision was made at the level of the groin, the external oblique was exposed and incised to identify both the scrotal neck and the previous tunnel to the scrotum. If it could be found, the previous tunnel usually commenced at the external ring or the spermatic cord. The scrotal neck was identified by palpation, and a tunnel was made to access the scrotum. Overall, the procedure was much easier when the implantation occurred immediately after the orchiectomy. When the incision was made on the scrotum, the spermatic cord was identified and a pouch was made for the prosthesis. The procedure was not difficult when the incision was made on the scrotum; in contrast, more difficulties were experienced when the incision was made in the groin. In delayed implantation cases, it was difficult to estimate the dimensions of the prosthesis. Therefore, we developed a new method to size the prosthesis. Instead of using a finger to detach the dense adhesions, we used a scrum dilator to create a pouch for the prosthesis. The dilator was composed of a main body, a jogger and a clamp. The main body was a hyponome with a rubber tube that could be dilated with water using a syringe (**Supplemental Figure 1**). This device determined the exact dimensions of the implants to be used and the position on the scrotum to fix the prosthesis. Bleeding was stopped with a gauze plug, and the cosmetic effects were evaluated (**Supplemental Figures 2 and 3**). One hole on each end of the prosthesis was used for fixation. Before fixation of the implants, the wound was irrigated with an iodine-based antiseptic. We used a device to clamp the base of the scrotum at the incision, and one side of the implant was affixed to this portion of the scrotum (**Supplemental Figure 4**). The other end of the prosthesis was attached to the spermatic cord if it was present. If the spermatic cord was not present, it was fixed to the tissue around the external ring (**Supplemental Figure 5**). After confirming satisfactory placement of the implants in the pouch, the incision was closed in layers with subcuticular sutures (**Supplemental Figure 6**).



Supplementary figures 2-6.

Supplemental Table 1 Testicular prosthesis questionnaire

Testicular prosthesis questionnaire

The six questions below concern your testicular prosthesis. Please circle the most appropriate answer

Is the size of the prosthesis correct?

Too big Just right Too small Scoring (1–10):

Is the weight of the prosthesis correct?

Too heavy Just right Too light Scoring (1–10):

Is the shape of the prosthesis correct?

Just right The shape is not right because _____ Scoring (1–10):

Is the position of the prosthesis correct?

Just right The position is not right because _____ Scoring (1–10):

Do you feel comfortable?

Very comfortable Comfortable Neither Uncomfortable Very uncomfortable

Have you had any other problems with your testicular prosthesis?

Supplemental Table 2 Questionnaire results

<i>Satisfaction variable</i>	<i>Available answers</i>	<i>Responses (n=20)</i>	<i>Satisfactory scoring (0–10 points, mean±s.d.)</i>
Size	Too big	0	9.1±1.41
	Just right	19	
	Too small	1	
Weight	Too heavy	0	8.05±2.58
	Just right	16	
	Too light	4	
Shape	Just right	20	9.4±0.68
	Not right	0	
Position in the scrotum	Just right	20	9.6±0.60
	Not right	0	

