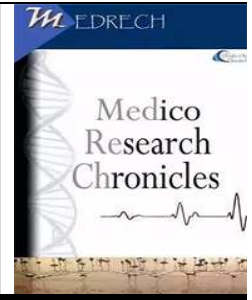




MEDICO RESEARCH CHRONICLES

ISSN NO. 2394-3971

DOI No. 10.26838/MEDRECH.2021.8.5.561

Contents available at www.medrech.com

FRACTURE PENIS IN A MALE IN THE SEVENTH DECADE OF LIFE IN A PANDEMIC SETTING

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ARTICLE INFO

ABSTRACT

CASE REPORT

Article History

Received: October 2021

Accepted: November 2021

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2021, www.medrech.com

INTRODUCTION

Penile fracture is considered a urological emergency caused due to direct trauma to an erect penis. Common causes include forceful manipulation, vigorous vaginal or anal intercourse, masturbation, other mechanical trauma that causes forcible bending of an erect penis. Lesser reported causes include sleeping prone, forced bending, or hastily removing or wearing clothing when the penis is erect (1). Taqaandan the practice of forcible detumescence is a commonly reported cause in Middle Eastern countries (2). During an erection, the thickness of the tunica albuginea decreases from 2 mm in the flaccid state to 0.25–0.5 mm, and therefore, the penis is more vulnerable to traumatic injury (3). The most common mechanism of injury is when the penis slips out of the vagina and strikes against the symphysis pubis or perineum or any hard surface like a tabletop. Patients

classically describe a popping sound followed by detumescence and swelling of the penile shaft. Fracture penis is usually encountered in a young patient and is exceedingly uncommon in a patient in the seventh decade of life. We herewith report such a case we recently had an opportunity to treat successfully.

CASE

A 63-year-old hypertensive male presented to ED with a history of pain and swelling of the penis following what he described as accidental trauma to an erect penis at around 4 in the morning. He did not complain of difficulty in passing urine, hematuria, or urinary retention.

General examination was within normal limits Groin examination revealed a swollen penis with a non-retractable prepuce hemorrhagic staining of penis and scrotum with scrotal edema (eggplant sign) (Figure 1). Scrotal contents were normal

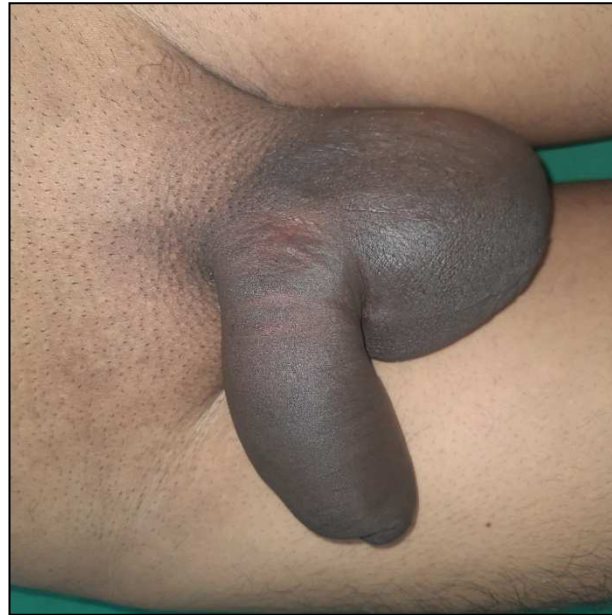


Photo 1 " Egg Plant deformity of Penis"

No radiological investigations were done. He was taken for surgical repair of the fracture under spinal anesthesia soon after

Intraoperatively a 2 cm tear was seen in the left corpora cavernosa 5cm proximal to the corona. (Figure 2).

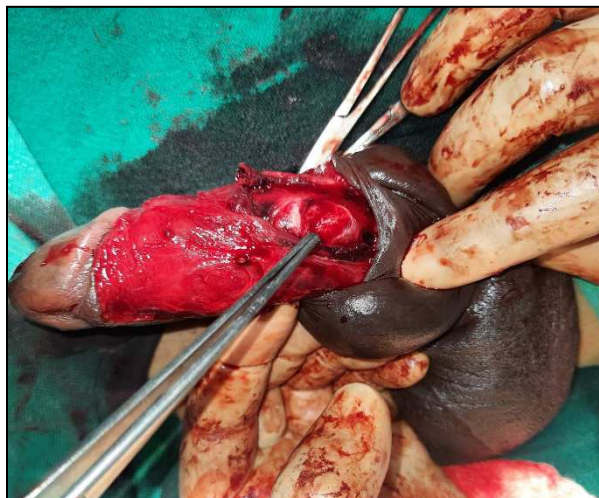


Photo 2 "Cavernosal Rupture on the left side of the penis"

Repair of corpora cavernosa done with CV6 sutures. Subcoronal incision was closed

with 2-0 vicryl interrupted sutures and a 16F foley's PUC was placed. Postoperatively he

was treated with a 5-day course of broad-spectrum IV antibiotics. PUC was removed on the 5th postoperative day. He was discharged on the 6th post-op day with a 5-day course of oral antibiotics to complete. The patient was

on regular follow. At 3 months, he had a well-healed surgical scar, normal penile and scrotal configuration (Figure 3). He reported having normal painless erections and no urinary symptoms of note.



Photo 3 "Followup at 3 months

DISCUSSION.

Penile fracture is a rare urological emergency. Diagnosis is mostly made by clinical assessment. However, ultrasonography study (USS) (4), cavernosography, Magnetic Resonance Imaging (MRI) (5), and retrograde urethrography (6), have also been used as diagnostic modalities especially in spurious cases or where extensive injury is suspected.

European Association of Urology (EAU) guidelines suggest that imaging (USS or MRI) may be useful in diagnosing penile fracture. (7).

Several studies have shown penile fractures mostly occur in middle-aged men with an average age ranging from 30-50 years (8). It is almost unheard of in the older population either due to them not seeking medical intervention or due to physiological changes which may result in lesser causes of trauma and hence the novelty in reporting this case. The mechanism of injury depends on sociocultural characteristics, masturbation

habits, and the specific sexual activities that an individual engages in.

Our literature review found that no data have been published regarding the time of occurrence of penile fractures. Most of the patients were injured in the late-night and early morning, which may reflect the circadian rhythm of testosterone secretion.

Prompt surgical management remains as the mainstay of treatment irrespective of the age of the patient with early surgical intervention having better patient outcomes and reduced complications. Multiple contemporary publications have confirmed that suspected penile fractures should be promptly explored and surgically repaired. Muentener et al (9) compared surgical and conservative treatment strategies and reported success rates of 92% and 59%, respectively. Although surgery has been shown to reduce the incidence of penile fracture complications, 6% to 25% of patients still experience long-term sequelae after surgery. Reported long-

term complaints after penile fracture repair include penile deviation, painful intercourse, painful erection, erectile dysfunction, priapism, skin necrosis, arteriovenous fistula, urethro cavernous fistula, and urethral stricture (10). The differential diagnosis of penile fracture may include a false fracture or rupture of the dorsal vein or the artery of the penis (11,12,13). An incidence of 4% to 10% false fractures has been reported (14).

CONCLUSION

Penile fracture is a urological emergency and should be managed promptly. Delay in presentation is mainly due to fear and embarrassment. Mechanism of injury depends on socio-cultural characteristics, masturbation habits, and indulgence in sexual activities. Diagnosis is usually clinical. Surgery is the treatment of choice. However, conservative treatment may be given in properly selected patients. Early intervention gives better outcomes but surgery should be offered in delayed presentation also to prevent long-term sequelae.

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