PENILE FRACTURE: OUTCOME OF EARLY SURICAL INERSENTION.

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Objective: To know the results of early surgical intervention in penile fracture.

Matarial And Methods: This is retrospective analysis of patients admitted to emergency department Lady Reading Hospital Peshawarwith penile fracture from 1-1-12 to 30-12-12. The total number of patients is 15. The diagnosis was based on clinical presentation and physical examination. Snap sound, pain, swelling, deformity, and hematoma were clinical signs. All patients were managed by sub coronal incision and rent repair by vicryl 3/0.

Results: The clinical diagnosis of penile fracture was accurate in all cases. All patients had a successful outcome with satisfactory erectile function.

Conclusion: Penile fracture is a clinical diagnosis and immediate surgical repair offers complete recovery of sexual function.

Keywords: Penile fracture, Early repair, outcome

INTRODUCTION

Penile fracture is an uncommon condition that presented to us in the emergency department, Lady Reading Hospital Peshawar. The true incidence is not known because may patients do not medical attention due to fear or social fearnious.[1,2] vaginal or common cause 2, 60% blunt trauma of the erect penis to achieve a sound antibodies a large percentage[3].

Masturbation is also reported as a cause of penile fracture. It can occur during a nocturnal erection due to the patient rolling over his own body. It is associated with urethral injury has occurred there may be urethral bleed, Hamaturia and difficulty in voiding may be observed[4]

The treatment of choice for penile fracture is immediate surgical repair. It presented complications like curvature, erectile dysfunction and early sexual activity. Conservative treatment has only place when patient refuses surgery.

Penile fracture is an entity of eminently clinical diagnosis, therefore the management of a penile fracture should not include any further investigation other than surgical exploration.[5]

Many conditions can simulate fracture penis as dorsal vein tears in penis may mimic penile fracture.[6]

The site of injury is variable but mostly occurs near the base of mid shaft.[7]

MATERIAL AND METHODS

This study consist of 15 consecutive patients who were admitted emergency surgical ward (Surgical C) between 1-1-12 to 30-12-12 with a diagnosis of penile fracture. All the patients gave a clear history of blunt trauma to the erect penis.

Assessment of the patient included a full history thorough examination, blood at the external meatus and side of penile fracture. The diagnosis was made clinically in all cases. None of the patient had haematuria or voiding difficulties no radiographic studies were done to the confirm the diagnosis. The entire patient underwent surgery on the day of presentation. The penis was explored through a circular sub coronal incision. The penis was degloved to allow thorough inspection of all three corporeal bodies. The haematoma was evacuated and the tear identified. The tear in the tunica albuginea was then closed with 3-0 vicryl. All patients received antibiotic i/v ceftriaxone 1 gm BD. A foley's catheter placed and removed on second day. Patients were discharged on antibiotics.

The patients have been followed up in the outpatient department with emphasis on sexual function (erection).

RESULTS

A total of 15 patients were diagnosed with penile fracture trauma occurred to erect penis in all cases of penile fracture, One had post sildenafil use the interval from injury to presentation was between 4 hours and one week. The mean age of the patients was 35 years, majority were married 14 patients under went surgical exploration out of all surgical patient.12 patients had disruption of tunica albuginea of right corpus carvernosum and 2 patient had on left side. All patients except I had uneventful recovery were discharged on 5th. The Hospital stay of operated cases was ____ from 5 to one week. All 15 patients were followed up in the outpatient clinic. Most of the patient returned to normal sexual activity.

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Table:

AGE	NO OF PATIENTS	PERCENTAGE
20 – 40	08	53.33
41 – 50	06	40
70	01	6.66
Marital Status:		
Marital status	NO OF PATIENTS	PERCENTAGE
Married	12	80
Unmarried	03	20
Duration of Presentation:		
Duration	NO OF PATIENTS	PERCENTAGE
24 Hours	05	33.33
1 – 3 days	08	53.33
7 days	02	13.33
Local Findings:		
Clinical Finding	NO OF PATIENTS	PERCENTAGE
Erection of the time of trauma	15	100
Audible Sounds	12	80
Ecchymosis	13	86.66
Swelling	12	80
Pain	10	66.66

DISCUSSION

The tunica albuginea, about 2 mm thick in the flaccid stat in one of the toughest fascias the human body. The thickness is reduced to 0.25 – 0.5 mm during erection and it becomes vulnerable to traumatic injury. The tunica albuginea has high tensile strength requiring a pressure of 1500 mm to achieve rupture[8]. There seems to be marked geographical variation with the highest reported incidence seen in countries of the Middle East and North America from where some of the longest published case series have originated[9].

The highest reported incidence is seen in North America 10. Corporal rupture typically occurs on the proximal shaft and is usually unilateral, bilateral corporal injury occurs is 4-10 of cases[11]. Vigorous sexual intercourse is the main cause of penile fracture in western world. Becouase of high energy trauma urethral rupture is associated in upto 38 % of penile fractures[12]. The majority of cases in the eastern world are results of patients snapping and kneading of their penis during erection to achieve detumesonce due to low energy trauma the urethral Farley involved. Surgical repair of penile fracture was first discussed by Fetter and Gactman in 1936.[13], and is now the gold standard for treatment of penile fracture.[14]

The treatment of penile fracture was highly controversial until the 1970's recommended conservative treatment for managing penile fracture. Consisting cooling, combined with Anti Inflammatus drugs, urethral catheterization, compression bandages, Anti- erection agents, and Antibiotics conservative treatment can lead to complications. Such as prolonged penile pain, curvature and erectile dysfunction.

Many techniques for the proposed, including penile deg loving, longitudinal incision over hematoma inguino-Scrotal incision on the rap he 15. In the present study circumferential degloving was employed.

REFRENCES

1. Orvis BR, Mc Anich JW, Penile Fracture Urol clin North Am 1989; 369-375
2. Eke N.Fracture of the penis. Br J Surg, 2002; 89 : 555- 565.
3. Zargooshi J. Penile fracture in Kermanshah, Iran: the treatment Br J urol Int. 2002, 89 : 890-894.
4. Khan RM, Malik MA Jmail M.Penile fracture: Experience at Teaching Hospital J ayub Nedical college Abbottabad 2008; 20(40): 140-46.
5. Guntero P, Muir GH, Frea P. Pathological findings of penile fractures and their surgical management. Urol Ibt 2003; 71: 77-82.
6. Bar-Yosef Y, Greentein A, Beri A, Lidawi G, Matzkin H, Chen J, Dorsal vein injuries observed during penile exploration for suspected penile fracture J sex med 2007; 4: 1142-1146.

7. Hinev A, fracture of the penis treatment and complications. Acta med okayama 2000; 54: 211-6.

8. De Rose Afetal (2001) traumatic rupture of the corpus cavernosa: new physiopathologie acquostion. Urology 57; 319-322.

9. Zargishi J (2000) penile fracture in Kermanshah, iran: report of 172 cases. J urol 164: 364-366.

10. Exe N (2001) fracture of the penis. Br J surg 89: 555-565.

11. Mydlo JH (2001) surgeon experience with penile fracture. J urol 166; 526-528.

12. Nasser TA and Mostafa T. Delayed surgical repair of penile fracture under local anesthesia. J sex Med. 2008; 5 (10): 2464-9.

13. Ei-Assmy A, El-Tholoth HS, Mohsen T and Ibrahim el HI. Long term outcome of surgical treatment of penile fracture amplicated by urethral rupture. J sex Med. 2010; 7(11): 3784-8.

14. El-Sherif AE, Daulah M, Allowneh N, etal. Management of fracture of penis in Qatar. Br J urol, 1991; 68: 622-625.

15. Gianini PTR, Pionesan ACP, Mesquita JLB-long term outcome of penile fracture treatment Int Bra 2 J urol. 2001; 27:46-49.