Fracture of the Penis: A Study of 9 Cases

Introduction and Objective: Fracture of the penis is not a new entity. More than 1331 cases are reported up to 2010. The earliest case was reported about 1000 years back by Arab doctor Abdul Kassam. Dr Charles Bordon, in 1770 gave a rough description. Largest series have been reported from Saudi Arabia and Iran. We present our series of 9 cases in last 15 years.
Materials and Methods: Seven cases were presented to us in less than 6 hours while 2 cases, came with delayed presentation (more than 3 days later). The majority of cases candidly accepted a female superior position just before the incidence. Only one patient gave some description of cracking sound. The remaining gave a history of sudden pain and swelling; it was soon followed by hematoma and bluish discoloration. All patients had passed urine immediately after the incidence. Clinically, all had typical swelling and hematoma on one side of penis, rendering a deformity. Six had it on right and 3 on left side. The meatus was normal and pain was intense. The definitive clinical diagnosis was made on local examination. The routine biochemical reports were normal. The USG in 4 cases, showed a distinct gap in corpora cavernosa with local hematoma. Corpora spongiosum was normal in all cases. Only in 1 case, rolling sigh or cracking sign could be elicited. The ages of all patients were between 30 to 40 years and were potent; hence, color doppler duplex ultrasound was not done. Ct scan or MRI was not done as in majority of cases; the diagnosis was straight forward, including those two cases, who reported late. All were advised immediate surgical therapy. All cases were done under spinal anesthesia. A circumcoronal incision was made. The skin was dissected up to the base of the penis. The large hematoma was seen under bucks fascia and in the majority, the tear was oblique. The buck fascia was incised. The hematoma was evaluated and tear was sutured by 3 zero vicryl suture. All knots were left inside. Thereafter bucks fascia was repaired by 4 zero vicryl and skin was approximated with 4 zero vicryl suture. The compression dressing was given. No foley catheter was kept postoperatively. No drains were kept postoperatively.
Results: All patients were discharged in 48 hours with compression dressing. They were instructed to avoid intercourse for 6 weeks and antibiotics were given for 7 days with analgesic for 3 days. Eight patients did well; there was no hematoma after 10 days, when the dressing was changed in theater. In one case small hematoma was seen, which was treated conservatively. All patients were reviewed for potency after 3 months. Seven had achieved a normal erection. One had a torsion at local site and 1 had a poor erection (delayed reported). The last two patients were given an option of sildanafil tablet.
Conclusions: Though a rare presentation, this paper gives a clear cut messages. The majority of cases can be diagnosed clinically. Thus, imaging has a limited role. It's only indicated in delayed presentation. Majority has a tear only on one side and urethra involvement is less than 10%. Majority of cases, need urgent surgical exploration with primary closure of corpora, which gives excellent results. Conservative therapy is associated with major complications like deviation, deformity and poor erectile status, post therapy.