DELAYED REPAIR OF A FRACTURED PENIS: A NEW TECHNIQUE

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SUMMARY Fracture of the penis can be managed conservatively or surgically. Conservative management is associated with a high morbidity, and early surgical repair of the fracture is usually recommended in order to prevent complications. Because a fractured penis is swollen throughout its length, it is difficult to identify the fracture site accurately, so a degloving technique is usually used to locate and repair the torn corpus cavernosum; this can lead to further trauma and complications. In cases where extensive swelling makes accurate clinical localisation difficult, delaying the repair for 7-12 days facilitates easy identification and repair of the torn corpus cavernosum. We report three cases where treatment was delayed until the swelling had subsided, when a simple direct repair was successfully carried out. (*Int J Clin Pract* 2003; **57(5):** 428-429)

Fracture of the penis can be managed conservatively or surgically. Conservative management is associated with a high morbidity due to late penile deformity, suboptimal painful erections, difficult coitus, pulsatile diverticulum and prolonged hospital stay.[1,2] Most studies recommend early surgical repair of the fracture in order to prevent these complications.[3] However, because a fractured penis is swollen throughout its length, it is difficult accurately to identify the fracture site; consequently, a degloving technique is usually used to locate and repair the torn corpus cavernosum. We have found, however, that the extensive diffuse swelling resolves rapidly in the first week, leaving a discrete, rounded, easily visible and palpable lump at the fracture site. This facilitates a simple direct repair without the need for degloving, by doing a small incision, as demonstrated by three recent cases. This technique, which greatly simplifies the operation, has not previously been described.

CASE 1

A 30-year old male sustained a fracture of the penis during intercourse. The site of the fracture in the corpus cavernosum was difficult to identify because of significant swelling and haematoma throughout the entire penis. He was advised to have it surgically repaired, but opted for conservative management. Twelve days later he returned and requested surgical repair, because he was having painful, deformed erections. At this time the diffuse swelling had almost completely resolved and a distinct site of injury could be seen and palpated, as a smooth, fixed and rounded 1.5 cm swelling. A 2 cm incision directly over the lump revealed this to be a firm clot deep to Buck's fascia lying directly over a tear in the corpus cavernosum. Evacuation of the clot revealed a 1.5 cm tear in the tunica, which was repaired with an interrupted 4/0 vicryl suture.

The patient was discharged the same day and had an uneventful recovery. Eighteen months later he was still having normal painless erections.

CASE 2

A 40-year-old male sustained a fracture of the penis during intercourse. On examination it was difficult to locate the site of the injury due to significant swelling over the entire penis; ultrasonography was not available. A simple repair[7] was attempted, but there was some difficulty in locating the site of the fracture and the procedure was abandoned. Ten days later the patient complained of painful erections. At this time most of the swelling had resolved, leaving a distinct 2.5 cm lump that could be seen and palpated on the ruptured corpus cavernosum away from the initial attempted repair site. This was visible and palpable as a smooth, fixed, rounded lump and was elicited using the 'rolling sign' at the missed fracture site. A 2 cm incision directly over the lump revealed a firm clot over a 1 cm tear in the tunica.

After clot evacuation, the torn corpus cavernosum was repaired with interrupted 4/0 vicryl sutures. The patient was discharged the same day and had an uneventful recovery. Fourteen months later he was still having normal painless erections.

CASE 3

A 23-year-old man presented six hours after sustaining a fracture of the penis during sexual intercourse. The penis was swollen and the fracture site was not obvious clinically. He passed urine normally. In view of our previous experience he was discharged on analgesics and advised to return seven days later for repair on our elective surgical list. On readmission, the swelling had decreased markedly and the fracture site was obvious as a 2 cm smooth, rounded,

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