

## Response to: Importance of time in management of fracture penis: A prospective study

Sir,

We congratulate Patil *et al.* on their case series of penile fractures. We do, however, feel compelled to comment on a few points which merit mentioning. First, we note the high rate of erectile dysfunction and wound infection approaching 50%, and we believe that one explanation for this may lie in the choice of incision. Penile-degloving incisions have been associated with complication rates as high as 60% including skin necrosis, hematoma, and wound infections.<sup>[1]</sup> This incision involves dissection through blood vessels and nerves along the entire penile shaft simply to repair a defect of <2 cm. We have utilized less morbid incisions in the past to good effect including both the penoscrotal incision and a direct incision over the site of fracture. The percentage of patients in whom the authors were able to clinically localize the tears was not disclosed in this study. However, in our experience, one is able to localize the site of fracture in most cases, and this lends itself to a direct incision over the site of injury and even under local anesthesia. Ultrasonography, done on all patients as a matter of protocol in Patil's work, was able to consistently localize the fracture site in this series; this could have directed the surgeon to a more localized incision rather than degloving the entire penis, damaging blood vessels, nerves, and normal tissue bilaterally just to repair a 1-cm tear at the base of one corpus cavernosum. All of the cases in this series involved a unilateral repair with mostly proximal injuries, thus making the penoscrotal incision another attractive alternative in these cases. In addition, in cases where extensive swelling precluded accurate localization of the site of fracture, one should not forget the role of delayed repair. While traditional doctrine has espoused early repair, delayed repair has been found to be a safe, practical, and efficacious alternative.<sup>[2,3]</sup> A delay of 7–12 days allows the resolution of generalized edema. However, the clot over the site of fracture remains trapped by Buck's fascia and is identifiable as “the rolling

sign.”<sup>[3]</sup> Repair may now be carried out through a simple incision directly over the site of injury utilizing local anesthesia. This approach has also been successfully applied by other authors with several relatively large series noting no difference in complications with delayed repair.<sup>[2,4]</sup> In a seminal prospective study, Nasser reported on delayed repair among 24 men presenting late (>24 h) following penile fracture. In this series, patients underwent conservative treatment for 7–12 days following which elective surgical repair of their fractures was carried out under local anesthesia. The authors report excellent outcomes with all patients regaining sexual function at 4–6 weeks.<sup>[2]</sup> As the authors themselves correctly point out, the correlation between erectile dysfunction and delayed intervention has not been objectively proven.

It is also worth mentioning that not all cases of urethral injury require repair. In cases where urethral injury is suspected, retrograde urethrogram is useful for confirmation. If a partial injury exists and the patient is voiding well, we have noted that urethral repair is often unnecessary.<sup>[5]</sup>

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### Conflicts of interest

There are no conflicts of interest.

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