



SKILL AND TALENT

Rotation of the corpora cavernosa for the treatment of congenital penile curvature[☆]



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KEYWORDS

Congenital penile curvature;
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Abstract

Introduction: Congenital penile curvature (CPC) is caused by a disorder in the embryonic development of the urethra and corpora cavernosa. The condition causes difficulty for penetration, requiring surgical correction when it prevents intercourse.

Material and methods: We present the cases of 2 men in their 40s who had ventral curvature greater than 60° of 2 years of evolution, with maintained erections. The patients underwent surgery for rotation of the corpora cavernosa. After the complete denudation of the penis, athermal release of the neurovascular bundle of the penis from the ventral side to the dorsal was performed. Once the curvature was verified using artificial erection, an incision was performed in the tunica albuginea of both corpora cavernosa, continuously suturing both internal and external margins with resorbable monofilament. The rectification of the curvature was then checked, and the mucocutaneous plane was reconstructed.

Results: The surgical time was 120 min and there were no intraoperative complications. Both patients were discharged 24 h after the surgery. At 1 week, the patients experienced spontaneous night-time erections and were able to maintain sexual relations 1 month after the surgery. At 6 months, the residual curvature was less than 20°, the penile shortening was less than 1 cm and the International Index of Erectile Function-5 was 25 for both cases.

Conclusions: Surgery for rotation of the corpora cavernosa helps correct CPC without significant penile shortening or erectile dysfunction. In our opinion, the procedure is an appropriate treatment for patients with CPC but requires studies with long-term follow-up in order to consider it the technique of choice.

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PALABRAS CLAVE

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Rotación de los cuerpos cavernosos para el tratamiento de la incurvación peneana congénita

Resumen

Introducción: La incurvación peneana congénita (IPC) está originada por una alteración en el desarrollo embrionario de la uretra y los cuerpos cavernosos. Condiciona dificultad para la penetración, precisando corrección quirúrgica cuando imposibilita el coito.

Material y métodos: Presentamos 2 varones en la 4.^a década de la vida que presentan incurvación ventral superior a 60° de 2 años de evolución con erecciones mantenidas. Los pacientes fueron sometidos a cirugía de rotación de los cuerpos cavernosos. Tras la denudación completa del pene se realiza la liberación atérmica del paquete vasculonervioso del pene desde la cara ventral hasta la dorsal. Una vez evidenciada la incurvación mediante una erección artificial se realiza una incisión en la albugínea de ambos cuerpos cavernosos, suturando de forma continua con monofilamento reabsorbible ambos bordes internos y externos. Posteriormente se comprueba la rectificación de la incurvación y se reconstruye el plano mucocutáneo.

Resultados: El tiempo quirúrgico fue de 120 min, no existiendo complicaciones intraoperatorias. Ambos pacientes fueron dados de alta a las 24 h de la intervención. A la semana presentaban erecciones nocturnas espontáneas, pudiendo mantener relaciones sexuales al mes de la intervención. A los 6 meses la incurvación residual era inferior a 20°, el acortamiento peneano inferior al centímetro y el IIEF-5 de 25 en ambos casos.

Conclusiones: La cirugía de rotación de los cuerpos cavernosos permite corregir la IPC sin acortamiento peneano significativo ni disfunción eréctil. En nuestra opinión constituye un tratamiento adecuado en pacientes con IPC, necesiéndose estudios con seguimientos a largo plazo para considerarla la técnica de elección.

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Introduction

Congenital penile curvature (CPC) is a pathological process that occurs in the last years of adolescence or early adulthood, its estimated incidence being 4–10% in the general population and 0.8% in patients with hypospadias.¹

CPC arises as a result of altered signaling pathways responsible for the embryonic development of the urethra and the corpora cavernosa, determining an increase in the ratio between elastic and collagen fibers in the tunica albuginea and the corresponding curvature.²

The curvature is ventral in 48% of the cases,³ and it conditions difficulty to achieve penetration, surgical correction being the treatment of choice in cases where it makes sexual intercourse impossible.

The choice of the surgical technique is determined by the size and degree of penile curvature. In cases of long penis and curvatures <60°, excision techniques (Nesbit) or plication of the tunica albuginea on the convex side are used, whose main risk is the shortening of the penis. In patients with short penis or curvatures >60°, enlargement techniques of the concave side by means of grafts are used preserving the penile length, although they are at risk of developing *de novo* erectile dysfunction.⁴

The rotation of the corpora cavernosa, first described by Shaer in 2006,⁵ makes it possible to preserve the length of the penis without risk of developing erectile dysfunction, existing to date few cases described in the literature.

Patients and methods

We present 2 men in the 4th decade of life complaining of congenital ventral penile curvature in erection above 60°, which prevents penetration over a year ago.

External genitalia showed no fibrotic plaques, or other alterations in any of the 2 cases.

We measured the length of the penis in detumescence in consultation with a millimeter ruler, being 15 and 12 cm. The curvature was observed by means of self-photographies in 3 projections. None of the 2 patients had erectile dysfunction. Sexual function was assessed using the IIEF-5 questionnaire, in both cases being 20.

Surgical technique

Circumcision is performed under spinal anesthesia, complete denudation of the penis up to Buck's fascia being performed by means of subcoronal approach.

On both sides of the urethra, 1 cm away from this, on the ventral surface, Buck's fascia is incised, initiating the release of this and of the neurovascular bundle. Dissection continues with scissors on both sides toward the dorsal side, coagulating small bleeding vessels selectively with bipolar forceps at 20 w.

After the release of the neurovascular bundle is completed up to the dorsal surface on both sides, indemnity thereof is checked and it is kept out with an elastic band.

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