

Penile Septoplasty for Congenital Ventral Penile Curvature: Results in 51 Patients

Giovanni Colpi, Guido Piediferro, Fabrizio Castiglioni, Gianfranco Contalbi and Luca Carmignani*

From the Andrological Urology Unit, University of Milano, San Paolo Hospital (GC, GP, FC, GC) and Department of Urology, University of Milano, Istituti di Ricovero e Cura a Carattere Scientifico Policlinico San Donato (LC), Milano, Italy

Purpose: The technique most widely used to correct congenital ventral penile curvature is still corporoplasty as originally described by Nesbit. We present results in patients treated with a variation of Nesbit corporoplasty used specifically for congenital ventral penile curvature.

Materials and Methods: From June 2000 to June 2007 we treated 51 patients with congenital ventral penile curvature using modified corporoplasty (septoplasty), consisting of accessing the bed of the penile dorsal vein and excising 1 or more diamonds of tunica albuginea from it, extending in wedge-like formation 4 to 5 mm deep into the septum, until the penis is completely straightened. Patient history, clinical findings, self-photography results and the International Index of Erectile Function score were assessed. Curvature grade is expressed using the equation, $180 \text{ degrees} - X$, where X represents the deviation in degrees from the penis axis. Mean preoperative ventral curvature was 131.4 degrees (median 135, range 145 to 110). Of the patients 13 also had erectile dysfunction.

Results: At followup postoperative mean ventral curvature was 178.3 degrees (median 179.1, range 180 to 175). A total of 49 stated that they were completely satisfied. Penile shortening was 5 to 15 mm. Compared to preoperative values there were marked improvements in the International Index of Erectile Function score in the various groups. No major postoperative complications developed. In 4 patients wound healing occurred by secondary intent.

Conclusions: This technique provides excellent straightening of the curved penis. By avoiding isolation of the whole dorsal neurovascular bundle there is no risk of neurovascular lesions. Suture perception is minimized.

Key Words: penis, penile erection, abnormalities, reconstructive surgical procedures, questionnaires

CORRECTING congenital ventral penile curvature to provide normal organ morphology and function basically consists of straightening the penis, which can be achieved by various different surgical techniques. The most common, best validated technique is still Nesbit corporoplasty,¹⁻³ which consists of excising paired ellipses of tunica albuginea from the dorsal surface of the corpora cavernosa. With

time various modifications of this technique have been proposed. The version reported by Ebbelohj and Metz consists of transverse plication of the albuginea at the same site⁴ with the possible variation of intracavernous embedding of the plication.⁵ Yachia⁶ and Sassine et al⁷ described longitudinal paired incisions of the tunica albuginea of the corpora cavernosa, which were sutured transversally. In

Abbreviations and Acronyms

IIEF = International Index of Erectile Function

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* Correspondence: Department of Urology, University of Milano, Istituti di Ricovero e Cura a Carattere Scientifico Policlinico San Donato, Via Morandi 30, 20097, San Donato Milanese, Milan, Italy (telephone: 39 02 5277 4329; e-mail: luca.carmignani@unimi.it).

2001 we reported a modification of the Nesbit operation consisting of excision of a diamond of tissue from the intracavernous septum.⁸ A similar technique was described by Giammusso et al in 2004 with excellent esthetic and functional results.⁹ We currently report results in our patients who underwent septoplasty for congenital ventral penile curvature.

MATERIALS AND METHODS

Surgical Technique

As described in 2001,⁸ the surgical technique involves circumcision, which pares enough prepuce for this to be able to cover the glans penis in resting conditions, circumferential incision of Colles' fascia and then separation of the dartos and Colles' fascia to the base of the penis, exposing Buck's fascia. After introducing 2 butterfly needles, including 1 in the retroglandular area of each corpus cavernosum, complete erection is induced by rapidly infusing physiological saline to evaluate the degree of curvature and determine the point of curvature on the convex surface of the penis, which is marked with a surgical pen. Buck's fascia is then opened with a median longitudinal incision to reach the bed of the deep vein of the penis, which is isolated and suspended on a vascular ribbon (fig. 1, A).

In the bed of the deep vein of the penis on the intercavernous septum and, therefore, not on the dorsal surfaces of the corpora cavernosa, as in the original Nesbit operation, a space is freed in the intercavernous groove (fig. 1, B). This space can be widened to as much as 1 cm

by gently opening the fine tips of a Klemmer curve. The groove is cut and a first transverse diamond of albuginea is excised with a long axis of about 5 to 8 mm (fig. 1, C). The short axis is as long as necessary depending on the extent of curvature. According to the Nesbit-Kelami technique the diamond must extend in wedge-like fashion 4 to 5 mm deep into the intercavernous septum.¹⁰ The residual defect is closed transversely with slowly absorbable 3-zero Monocryl™ suture (fig. 1, D). Repeat artificial erection is then induced to determine the extent of straightening and decide where to excise a second and rarely a third diamond, as necessary.

After satisfactory penile straightening is achieved the operation is completed by replacing the deep dorsal vein and closing Buck's fascia with a continuous midline tied suture with 5-zero polyglactin rapid with care taken to control hemostasis and irrigate the field with antiseptic solution (160 mg gentamicin in 250 ml saline solution). The skin covering is replaced, the margins of Colles' fascia are sutured with 4 to 8 separate stitches and the circumferential skin incision is closed. A urethral catheter is placed in situ for 24 hours and a gentle compression dressing is applied to the penis, which rests on the abdomen. Figure 2 lists the steps of our method.

Patients

From June 2001 to June 2007 we used the described technique for penile straightening in 51 patients with a mean age of 25.2 years (median 25, range 17 to 35) with congenital ventral penile curvature, excluding those with urethral chordee from analysis. Ventral curvature was associated with a left lateral deviation in 10 cases and a

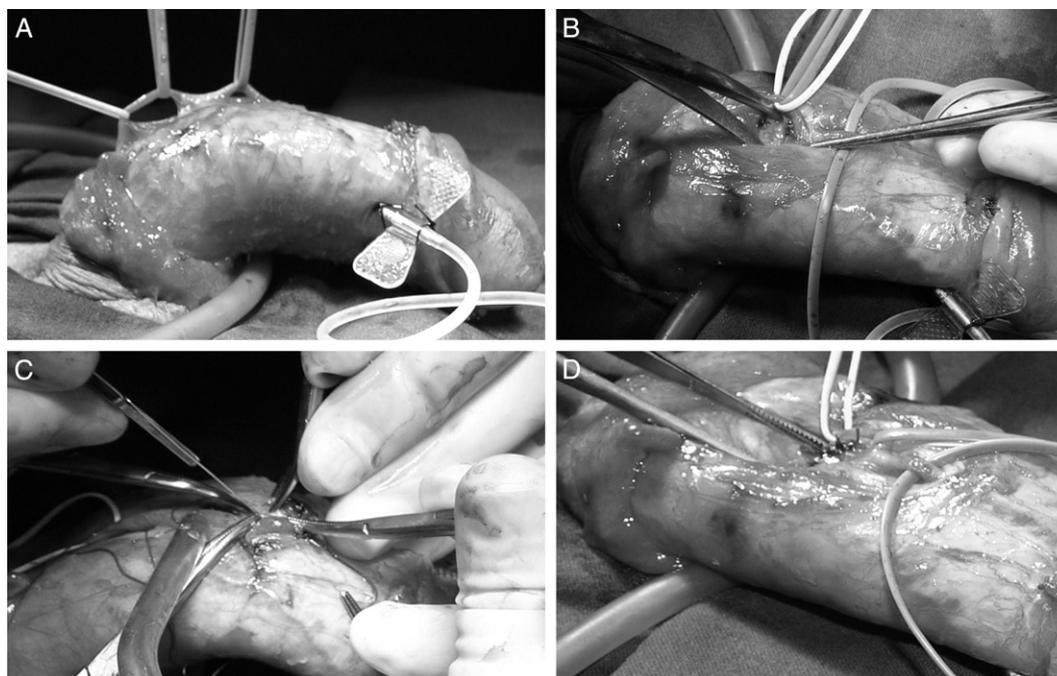


Figure 1. A, isolation of deep penile vein. B, creation of space in intercavernous groove. C, groove is cut. D, transverse closure of residual defect after excising diamond.

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