

The Reduction Corporoplasty: The Answer to the Improbable Urologic Question “Can You Make My Penis Smaller?”

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ABSTRACT

Introduction. Aneurysmal dilatation of the corpora cavernosa can occur because of recurrent priapism in the setting of sickle cell disease.

Aim. We present the first case of a successful implementation of the reduction corporoplasty technique for treatment of a phallus that was “too large for intercourse.”

Methods. We describe the presentation of a 17-year-old male with a history of sickle cell disease with a phallus “too large for intercourse.” Patient reported normal erectile function and response with masturbation but also reported inability to penetrate his partner due to the enlarged and disfigured morphology. He had three priapismic episodes since the age of 10 that progressively led to an aneurysmal morphologic deformity of his phallus. Evaluation included a magnetic resonance imaging, which revealed true aneurysmal dilatation of bilateral corpora cavernosa in the middle and distal portions, and diffusely hyperplastic tunica.

Main Outcome Measure. The main outcome measure is the successful management of phallic disfiguration.

Results. Reduction corporoplasty was performed, and the patient reported intact erectile function without aneurysmal recurrence.

Conclusions. Patients with significant corporal aneurysmal defects secondary to recurrent priapism can be successfully managed with reduction corporoplasty. **Martinez DR, Manimala NJ, Rafiei A, Hakky TS, Yang C, and Carrion R. The reduction corporoplasty: The answer to the improbable urologic question “Can you make my penis smaller?” J Sex Med 2015;12:835–839.**

Key Words. Reduction Corporoplasty; Priapism; Corporal Hypertrophy; Penis; Erectile Function; Pediatric; Sexual Dysfunction; Sickle Cell Disease

Introduction

There comes a time in every urologist’s career that a patient makes a request so rare and impossible to comprehend that all training breaks down and leaves the physician speechless. That question was “Can you make my penis smaller?”

Penile size often plays an important role when it comes to a man’s psyche. Many men and women focus or obsess over the length, shape, curve, girth, and contour of the male phallus. It seems that we live in a “penis-centric” society. Average stretch penile length and circumference

have been reported to be 13 cm and 9 cm, respectively [1]. Most men and some women would prefer a longer, thicker penis, but rarely will you encounter a situation where a phallus is so long and bulky that the deformity is not compatible with penetration, causing discomfort to the partner and even causing the patient daily grief because of how unsightly it appears in normal street clothes. The sensitivity of the issue is compounded when the patient involved is a young man who is unable to successfully engage in sexual intercourse because of this substantial morphologic deformity.

Aim

We present the case of such a patient with substantial phallic deformity and describe the surgical correction of this problem, the reduction corporoplasty.

Methods

A 17-year-old male presented to the urology clinic complaining of a phallus that was “too large for intercourse.” He reported a history of three priapismic episodes, secondary to sickle cell disease—the first when he was 10 years old and the last when he was 15 years old. He reported anatomical structural deformities to his phallus that developed gradually over the three episodes. Two out of the three episodes required irrigation in an emergency room setting. He had been on hydroxyurea since the last episode and had not had any further sickle cell crisis since starting this medication.

The patient reported normal erections, orgasms, and ejaculation with masturbation. He denied penile pain. He wished to be sexually active and had several situations where intercourse with vaginal penetration was not possible because of the girth of his phallus, causing pain and discomfort to his partner. Hence, he has never been able to complete coitus.

The patient also reported difficulty wearing his pants due to his large and heavy phallus with the corresponding social embarrassment because of how visible this defect was to the public (Figure 1B). Further compounding this issue was the fact that this individual was a competitive football player.

A magnetic resonance imaging was ordered to evaluate the corporal bodies and surrounding tissues. The penis measured 17 cm in length and 8 cm in diameter, with maximal circumference of 25 cm. Both corpora cavernosa were enlarged in a fusiform manner, with bilateral aneurysmal dilation of corpora in the middle and distal portions. The tunica appeared to be diffusely hyperplastic bilaterally (Figure 1A).

After the risks and benefits were explained to the patient, informed consent was obtained for reduction corporoplasty, and he was taken to the operating room. A circumferential incision was made around his old circumcision scar (Figure 1C). The penis was then degloved using bovie cautery, which also helped to obtain hemostasis (Figure 1D). At that time, it was easy to appreciate the aneurysmal dilation of the corpora distally and bilaterally.

Elliptical incisions were then made over the lateral aspects of both corpora, incising a longitudinal ellipse of the aneurysmal corpora (Figure 1E). These lateral sections were purposely selected to avoid harming the dorsal neurovascular bundle and ventral corpora spongiosum. This was done initially with the bovie cautery to score the corpora, and an elliptical wedge of aneurysmal corpora was excised with sharp Metzenbaum scissors (Figure 1F). The corpora were noted to have healthy bleeding smooth muscle surrounded by a thick collagen rind. The edges of the elliptical incisions were reapproximated using Allis clamps in transverse fashion (Figure 1G). This also ensured that an adequate amount of aneurysmal tissue had been excised for a more normal-appearing phallus. These clamps also assisted with closure of the defect, which was done with 3-0 Vicryl sutures (Ethicon Inc., Somerville, NJ, USA) in an interrupted, water-tight fashion (Figure 1H). Once the elliptical corporal reduction was completed, the phallus was again inspected for symmetry, adequate reduction, and complete removal of the aneurysmal sacs (Figure 1I). Two Jackson-Pratt (JP) drains were left on each side and brought out through a separate stab incision. The dartos layer was closed using 3-0 Vicryl sutures in an interrupted fashion, followed by 3-0 chromic sutures on the skin in an interrupted fashion for the circumcision incision (Figure 1J). Phallic shaft skin was not reduced because it did not appear redundant and ease of closure was anticipated.

Results

Outcome was determined by assessing the patient's self-reported sexual function and by monitoring the cosmetic morphology of the phallus.

The patient was monitored overnight and on postoperative day 1, the JP drains were both removed, as the outputs were minimal over 24 hours. The patient was discharged with a compressive dressing in place for 48 hours, which was removed at home.

On subsequent postoperative visit, he reported good erectile function with masturbation, but had not reported any sexual activity as of yet. He had not had any recurrence of his aneurysmal deformity and denied any penile pain.

Discussion

Reduction corporoplasty can be a viable intervention for patients with large and/or deformed

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