Skin Reduction Technique for Correction of Lateral Deviation of the Erect Straight Penis

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ABSTRACT

Introduction. Lateral deviation of the erect straight penis (LDESP) refers to a penis that despite being straight in the erect state, points laterally, yet can be directed forward manually without the use of force. While LDESP should not impose a negative impact on sexual function, it may have a negative cosmetic impact.
Aim. This work describes skin reduction technique (SRT) for correction of LDESP.
Methods. Counseling was offered to males with LDESP after excluding other abnormalities. Surgery was performed in case of failed counseling. In the erect state, the degree and direction of LDESP were noted. Skin on the base of the penis on the contralateral side of LDESP was excised from the base of the penis and the edges approximated to correct LDESP. Further excision was repeated if needed. The incision was closed in two layers.
Main Outcome Measure. Long-term efficacy of SRT was the main outcome measure.
Results. Out of 183 males with LDESP, 66.7% were not sexually active. Counseling relieved 91.8% of cases. Fifteen patients insisted on surgery, mostly from among the sexually active where the complaint was mutual from the patient and partner. SRT resulted in full correction of the angle of erection in 12 cases out of 15. Two had minimal recurrence, and one had major recurrence indicating re-SRT.
Conclusions. LDESP is more common a complaint among those who have not experienced coital relationship, and is mostly relieved by counseling. However, sexually active males with this complaint are more difficult to relieve by counseling. A minority of patients may opt for surgical correction. SRT achieves a forward erection in such patients, is minimally invasive, and relatively safe, provided the angle of erection can be corrected manually without force.
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Key Words. Penile Deviation; Penile Curvature; Bent Penis; Penile Bending; Lateral Deviation of the Erect Straight Penis; Skin Reduction Technique

Introduction

Deviation of the straight penis in the erect state is an overlooked condition where the erect penis points elsewhere than forward, whether laterally or downward, despite being straight. The term "penile drop" (PDR) has been applied to the situation where the erect penis points downward despite being straight, possibly because of a congenitally absent or defective penile suspensory ligament (PSL) [1] or because of traumatic rupture of the PSL at sexual intercourse. Surgical correction is by nonabsorbable sutures placed between the symphysis pubis and the tunica albuginea of the penis, anchoring the penis backward [1,2], in addition to adjuvant techniques such as Nesbit's procedure [1].

On the other hand, lateral deviation of the erect straight penis (LDESP) has not been investigated by far to the best of the author's knowledge, and no particular etiology has been described. LDESP refers to a penis that points laterally when erect, despite being straight, yet can be redirected forward by manual correction, without the use of

force. While LDESP should not impose a negative impact on sexual function considering that the angle of erection is manually correctable, it may have a negative cosmetic impact, which may raise complaints to the medical specialist. This is in contrast to congenital or acquired curvature of the erect penis that may defer coital activity in addition to raising aesthetic concerns. Theoretically speaking, males complaining of LDESP can be relieved by counseling. However, some may find it difficult to adapt to LDESP. To the knowledge of the author, no particular surgical technique has been described to handle those cases.

This work describes skin reduction technique (SRT) for correction of LDESP, in addition to the role of counseling in relieving males with this condition.

Methods

Through 3 years (2006 to 2009), 822 males presented to an andrology health care service with the complaint of a non-straight penis, expressed as penile deviation, penile curvature, bent penis, abnormal erection angle and in some cases; impotence. Presentation was either to the outpatient clinic or via an online consultation service. As a preliminary screening test, all patients were asked to fill in the abbreviated version of the International Index of Erectile Dysfunction (IIEF-5) [3] and provide a self-picture of the penis in the erect and flaccid states, upper and lateral views. Accordingly, patients with an anatomical abnormality were directed to the appropriate investigations and management, while those without were directed to counseling, with the exception of patients who insisted that they had an abnormality contrary to medical opinion, who were guided to confirmatory investigations besides counseling. For cases with an anatomical abnormality or cases insisting that they suffer an abnormality despite lack thereof, investigations performed included examination after induction of artificial erection using intracavernosal injection (ICI) of prostaglandin E1.

Cases with penile curvature (congenital and acquired), PDR, and erectile dysfunction (ED) were excluded from the current data set and so were cases where the abnormality was in the flaccid state rather than the erect. Only cases with normal erection (as per IIEF-5 and ICI testing) and an erect straight penis pointing laterally were included in the current study: patients with LDESP.

LDESP patients received sexual counseling through which they were informed that their condition is a variant of normal and is not an obstacle to satisfactory coital relationship. Further psychological counseling was provided to those who were not relieved still, particularly those in celibacy, who were in addition advised to wait until they are in a sexual relationship before coming to a conclusion on their condition. None of the sexually active patients agreed to include their partners in counseling activities.

Fifteen patients with lateral deviation insisted on surgical correction, providing written informed consents with the details of their conditions, the counseling offered, the surgical intervention intended, and its possible outcome and complications. In addition to LDESP, a prerequisite for surgical correction using SRT was the ability to manually correct the angle of erection with ease, without any kind of force, to exclude possible undetected curvature where the pivotal point of curvature is buried within the mons pubis.

Surgery was performed under general anesthesia, in the erect state as induced by ICI of 20 μg prostaglandin E1. The degree and direction of LDESP were noted (Figures 1A and 2). Skin on the base of the penis on the contralateral side of LDESP was pinched to determine the extent of skin reduction required to correct LDESP (Figure 1B). Skin was marked and excised in a dome shape with the base aligned with the base of the penis (Figure 1C). Part of dartos muscle may be excised to avoid formation of a subcutaneous swelling. However, dartos excision should be kept to a minimum to avoid long-term edema. Skin edges were approximated to check for the success of

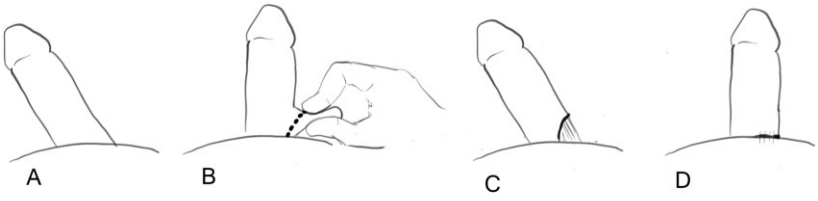

Figure 1 Illustration of surgical technique. (A) LDESP. (B) Correction by pinching and marking of the skin area to be excised. (C) Skin excised. (D) Correction by approximation of skin edges. LDESP = lateral deviation of the erect straight penis.