

Dry Gangrene of the Foreskin after Second Attempt at Prepuce-Sparing Surgery for Congenital Penile Curvature: Case Report and Literature Review

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ABSTRACT

Introduction. Dry gangrene of the foreskin following corrective surgery for congenital penile curvature (CPC) or Peyronie's disease is extremely rare. It is noted as a consequence of intraoperative penile degloving.

Aim. We report one such case with its natural history presented by serial clinical pictures, discuss the management dilemmas, and review a rather scant relevant literature.

Methods. A 32-year-old man with CPC underwent prepuce-sparing corrective surgery for penile curvature on two occasions resulting in dry gangrene of the foreskin following the second attempt.

Results. It was managed conservatively with a satisfactory result.

Conclusion. Gangrene of the foreskin is most likely to occur as a complication after a second attempt at prepuce-sparing surgery. It can be managed nonsurgically with a satisfactory outcome. **Chitale S, and Sethia K. Dry gangrene of the foreskin after second attempt at prepuce-sparing surgery for congenital penile curvature: Case report and literature review. J Sex Med 2008;5:2951–2955.**

Key Words. Congenital Penile Curvature; Degloving; Postoperative Complication; Peyronie's Disease; Natural History; Gangrene

A 32-year-old man presented with congenital penile curvature (CPC). The deformity, measured with a 360°-angle measure on an erect penis post-intracavernosal injection of prostaglandin E1 (ICI-PGE1), was a 50-degree angulation to the right at the level of midshaft and a 10-degree dorsal bend. Penile length was 19 cm. There was no evidence of hour glass deformity or twisting of the shaft. He had no medical comorbidities, was not yet sexually active, and was uncircumcised. Maintaining penile length and the foreskin were two of his primary concerns. Using a circumcoronal approach, corrective penile surgery was performed with incision of the tunica along the dorso-lateral aspect of the right corpora and insertion of two saphenous vein grafts (venous patch graft procedure) followed by two small corporoplasties (Nesbit procedure) along the left side to address a minor residual curvature. The operation was technically difficult, and despite a combined procedure, a residual deformity of 5–10 degree was noted on full intraoperative erection. Further

surgery was not performed in order to minimize penile shortening. Venous patch graft technique was used as a primary corrective procedure in view of the severity of the curvature and the patient's desire to maintain penile length and preserve the foreskin. Postoperatively, he developed cellulitis of the foreskin and distal penile skin, which responded to expectant management with intravenous hydration and flucloxacillin (500 mg every 6 hours for 5 days). Surgical outcome in the given circumstances was considered satisfactory with ≤10 degree residual deformity, and the patient was happy with the aesthetic aspects of the erect penis particularly with an intact foreskin. There was no evidence of erectile dysfunction (ED) pre- or postoperatively with an International Index of Erectile Function (IIEF-5) score of 24 and 23, respectively. At 6 months follow-up, the patient was pleased with the degree of straightening achieved following the surgery, but was concerned about minor bulging at the site of venous grafts. He was advised that any further surgical

intervention may lead to scarring and recurrence of his bend, and a regular review was arranged in 6 months time.

However, after 3 years, he requested further corrective surgery for residual penile deformity/bulging to improve his “self image” and confidence. On preoperative evaluation with 360°-angle measure on a post-ICI (PGE1) erect penis, the residual deformity was still stable at around ≤ 10 degree, a penile length of 19.5 cm, and no evidence of ED (IIEF-5: 23). He requested a second opinion.

After appropriate preoperative surgical counseling with emphasis on outcome expectations from repeat corrective surgery, namely, degree of angulation and penile length, a redo venous patch procedure at the site of bulging and a small corporoplasty (Nesbit’s procedure) were performed via a circumcoronal approach, at another center. The penile length was maintained, and despite advice to the contrary, the foreskin had to be preserved at the patient’s request. A week later, he presented to us with dry painless gangrene of the foreskin (Figure 1A) with a clear cut line of demarcation and no involvement of the glans or corpora cavernosa. There were no risk factors for abnormal wound healing or infection. There were no intraoperative risk factors that envisaged postoperative complications. The gangrenous foreskin was managed with oral flucloxacillin (500 mg every 6

hours for 5 days), to prevent the risk of local infection, and diclofenac suppositories as nonsteroidal anti-inflammatory, to address secondary/reactive inflammation around the dry gangrenous foreskin. Ten days later, the gangrenous foreskin separated spontaneously along the line of demarcation (Figure 1B). Wound healing was complete (Figure 1C) a week later. At 12 weeks follow-up, the patient denied ED, paresthesia of the glans penis, and had no urinary symptoms but remained disillusioned about the overall outcome.

Discussion and Literature Review

CPC is a rare disorder with an incidence of 0.4–0.6% reported in the literature [1,2]. It is reported with or without associated urethral anomalies such as hypospadias/epispadias [3,4]. ICI is the gold standard for measurement of degree of curvature of penile deformity as the other methods are known to underestimate it [5]. A number of surgical procedures are described in the literature for its correction with associated complications, such as penile shortening, subcutaneous nodules/scars, residual/recurrent curvature, ED, and glans paresthesia, depending upon the type of procedure performed. Grafting procedures to straighten the penis using various types of grafts have been shown to achieve up to 90% patient satisfaction assessed by IIEF-5,

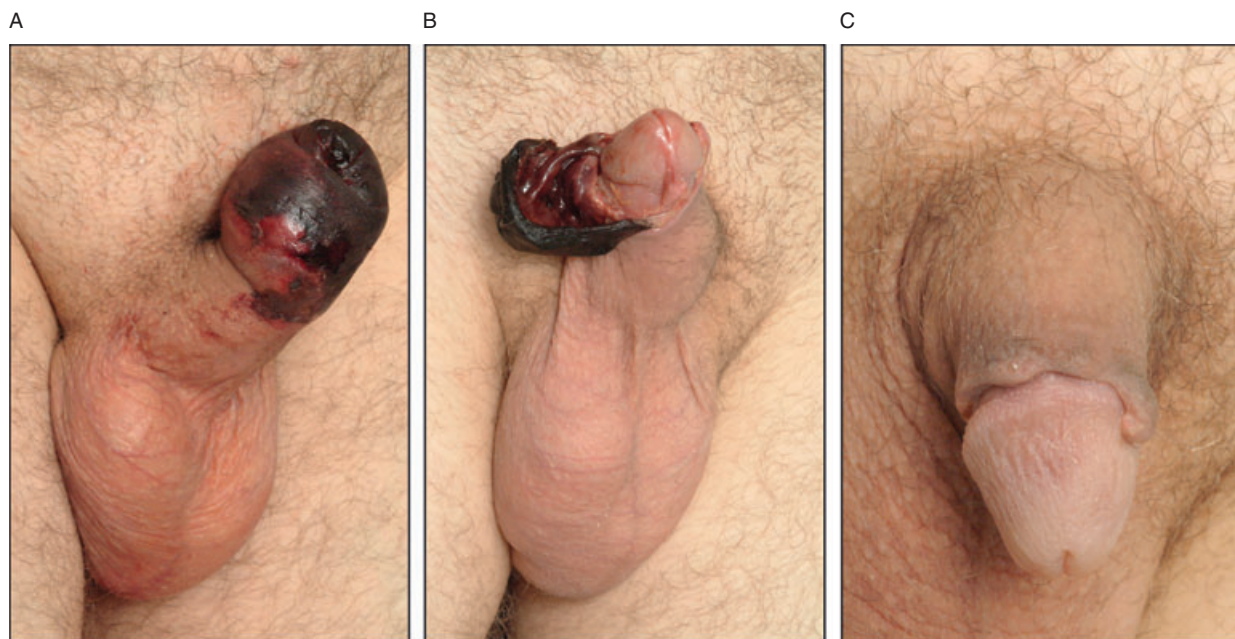


Figure 1 (A) Dry gangrene of the foreskin noted on the seventh postoperative day. (B) Gangrenous foreskin spontaneously separating along the line of demarcation at the end of 2 weeks. (C) Complete wound healing after spontaneous separation of the devitalized foreskin on the 24th postoperative day.

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