



ORIGINAL ARTICLE

Modified prepuce unfurling for buried penis: A report of 12 years of experience



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prepuce

Summary *Background/Objective:* About 10 years ago, we started to correct buried penis using the technique of modified prepuce unfurling. We have made modifications in the years since our preliminary results were reported in 2002.

Methods: One hundred and thirty-four patients received modified prepuce unfurling since 2000, with ages ranging from 2 months to 33 years. The surgical procedures included the removal of the narrowest part of the prepuce, dissection of the fibrotic tissue from the Buck's fascia, and unfurling the inner prepuce to cover the penis. Most patients had their procedures in day care service. No urinary catheter was needed. All patients were followed up for at least 2 months.

Results: Most patients had satisfactory results. All patients had the glans exposed after surgery, although one patient needed reoperation for prolonged edema and two patients had wound infections.

Conclusion: Modified prepuce unfurling is a safe and effective method to correct buried penis. Copyright © 2014, Asian Surgical Association. Published by Elsevier Taiwan LLC. All rights reserved.

1. Introduction

Buried penis is a congenital anomaly that affects the appearance and the function of the external genitalia in boys and men. This anomaly is frequently associated with

insufficient outer penile skin, inadequate subcutaneous attachment to the Buck's fascia, and usually, a narrow opening of the prepuce. Surgical correction may be needed because of ballooning of the foreskin while voiding, urine dripping, balanitis, or urinary tract infection, but more often, for the abnormal appearance of the external genitalia.

Numerous surgical techniques have been developed for the correction of this anomaly. Although prepuce unfurling is a relatively simple way to correct the anomaly,¹ some patients have prolonged edema after surgery. About 12 years ago, we modified the procedure of preputial unfurling.² In this retrospective report, we describe our

Conflicts of interest: All authors declare no conflicts of interest.

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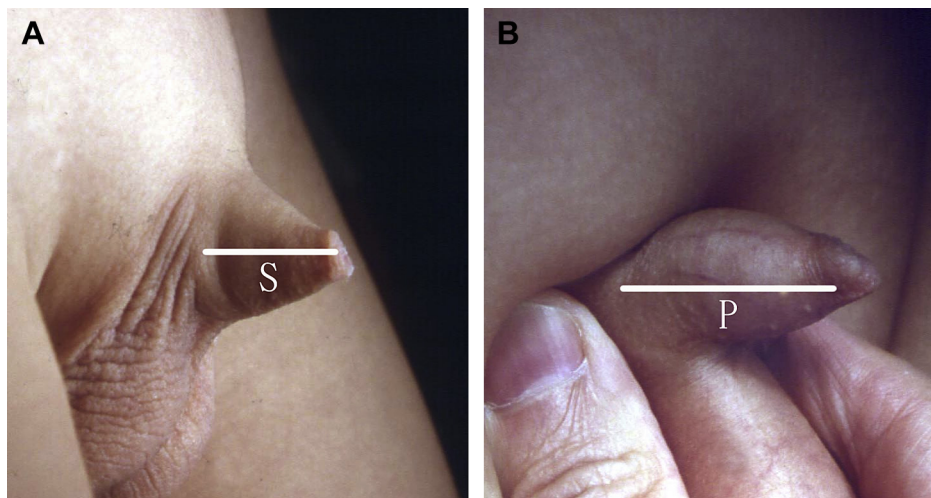


Figure 1 (A) Measuring the length of penile skin (S) with no or mild skin stretch; (B) measuring the length of the phallus (P) by compression of the prepubic fat.

experience of the procedure and the results in 134 patients.

2. Materials and methods

In order to document the severity of buried penis, we developed a method to quantify the anomaly by measuring the length of the penile skin (S) and penile shaft (P) (Fig. 1). S was measured when the penile skin was gently stretched; P was measured by pressing the prepubic fat at the penile base. The severity of buried penis was recorded as S/P ratio ($S/P \times 100\%$). We evaluated patients who visited our clinic with complaints of buried penis and separated them into three groups: Group A (severe deficiency of penile skin, S/P ratio $< 30\%$); Group B (moderate deficiency of penile skin, S/P ratio 30–70%); and Group C (mild or no deficiency of penile skin, S/P ratio $> 70\%$) (Fig. 2). Only the patients in Groups A and B were operated using the technique described here.

Since 2000, 134 individuals (36 in Group A, 98 in Group B) with buried penis were operated upon using our modified preputial unfurling. No patient in this series had previous circumcision or other genital surgery. Group C patients (mostly obese patients) were excluded from this procedure.

Medical records of the patients were reviewed and analyzed.

All patients underwent surgery with general anesthesia. To minimize postoperative pain, the patients either had caudal blocks provided by anesthesiologists immediately after general anesthesia or regional blocks with 0.5% bupivacaine (Marcaine) by surgeons just after the surgical procedures. The surgical techniques were performed as described previously,² but with certain modifications since the last publication.

The procedure started with opening the phimosis by removing the narrow ring of the foreskin (Fig. 3A). Under adequate traction, the inner preputial skin was separated from its subcutaneous tissue and the outer skin. The dissection of the inner skin continued to the penile base. In most patients, detaching the fibrous tissues from Buck's fascia was necessary to release the trapped phallus (Figs. 3B and 4). Some subcutaneous tissues between the inner and outer penile skin were removed to reduce edema after surgery. The inner penile skin might need tailoring to an adequate size prior to being fixed to the Buck's fascia of the proximal phallus (Fig. 3C). The outer skin was approximated to restore the skin covering of the penile shaft (Fig. 3D). We used chromic catgut as suture material in the first few years, but changed to 5-0 PDS (Ethicon) later to reduce

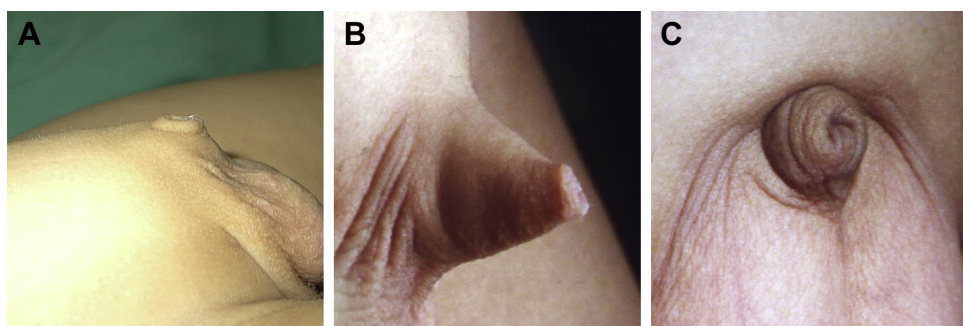


Figure 2 (A) Group A: severe penile skin deficiency; (B) Group B: moderate penile skin deficiency; and (C) Group C: mild penile skin deficiency, much prepubic fat.

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