Case Report

Hidden penile fracture: An unusual presentation and review of literature

Sagar Sabharwal, Arun Jacob Philip George, J. Chandra Singh

Department of Urology, Christian Medical College, Vellore, Tamil Nadu, India

Abstract Penile fractures, a not so uncommon urological emergency, mostly present with a characteristic history and physical examination. Here, we present an atypical case where even in the absence of physical findings, a characteristic history led us to penile exploration and timely repair, highlighting the importance of careful history-taking in these cases.

Key Words: Penile fracture, rupture, surgery, treatment

Address for correspondence:
Dr. Sagar Sabharwal, Department of Urology, Christian Medical College, Vellore, Tamil Nadu, India. E-mail: thatsagar@gmail.com
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INTRODUCTION

Penile fractures present with a typical history and characteristic findings. Here, we describe an atypical case and review the literature.

CASE REPORT

A 30-year-old gentleman heard a popping sound followed by sudden detumescence during sexual intercourse in the female superior position. Subsequently, however, he allegedly had another erection after a gap of two hours, which was normal though associated with mild pain. There was no bleeding per urethra or difficulty in voiding. He sought medical help more than – 24 hours after the incident.

Penile examination was unremarkable and thus misleading, with no edema or hematoma of the penile shaft, and no palpable rent in the albuginea. A dorsal Peyronies plaque and mild tenderness on the distal ventral penile shaft were the only positive signs.

Although the physical findings were not suggestive of a penile fracture and the patient allegedly had achieved a normal erection following the initial episode, exploration was undertaken in view of a typical history.

Penile ultrasonogram revealed small hematomas in the region of the left corpus cavernosum and the right side of spongiosum; however, no defects in the albuginea were picked up.

Using a circumcoronal incision, the penis was degloved, exposing the tunica albuginea. No obvious hematoma or rent was visible either in the tunica albuginea around the cavernosa or in the spongiosum.

Thus, though there was an initial suspicion of a negative exploration, a careful review of the history, examination, and imaging led us to explore the most ventral distal aspect of the corpora cavernosa hidden by the spongiosum [Figure 1].

Dissecting the spongiosum off the cavernosae revealed a sudden gush of a small amount of altered blood suggestive of a concealed hematoma followed by visualization of a 1 cm long tear in the tunica albuginea in the distal ventral shaft, approximately

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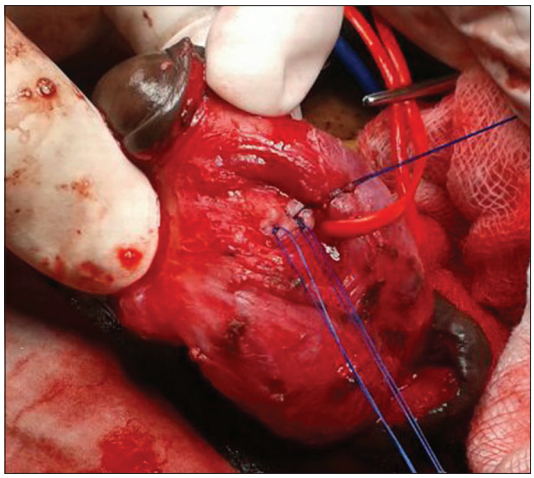

Figure 1: Tear in the tunica albuginea in the distal ventral most shaft

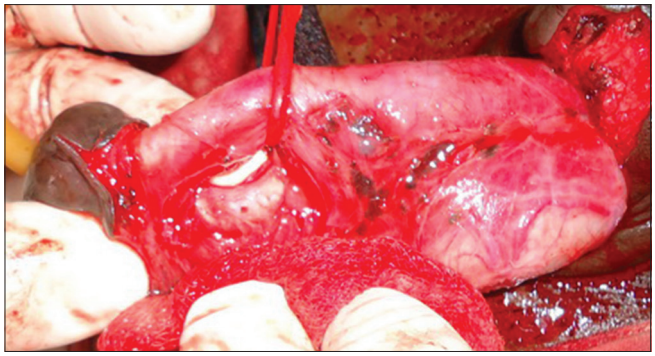

Figure 2: Tunical repair with absorbable 3-0 interrupted sutures with buried knots

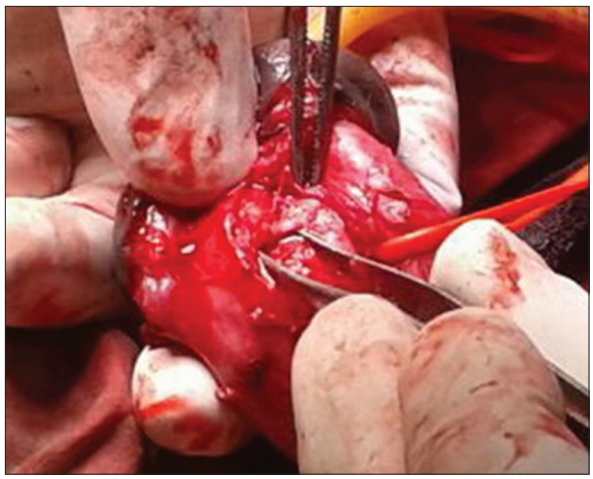

Figure 3: Spongiosum dissected off the corpus cavernosum revealing the ventral most aspect of cavernosae

2 cm proximal to the glans [Figure 2]. This was repaired with absorbable 3-0 interrupted sutures with buried knots [Figure 3].

DISCUSSION

Reported first by Abul kasem in Cordoba more than a thousand years ago, fracture penis represents a traumatic breach in the tunica albuginea in the erect state. Its incidence is on the rise; however, it may still be under-reported due to associated guilt and embarrassment. The etiology varies, with penile manipulation during masturbation and 'taghaandan' (in Kurdish meaning to click or snap) being common in Middle East, whereas vigorous sexual intercourse being the major cause in the West. Certain sexual practices and positions like the female superior or the rear entry vaginal/anal intercourse are an added risk for penile fracture.[1-3]

Primarily, a clinical diagnosis, the history, and physical examination are typical. A popping, snapping, or cracking sound is usually reported at the time of sexual intercourse or penile manipulation followed by pain and sudden detumescence. Penile swelling, hematoma, discoloration, and deviation follow, which have been described as the 'eggplant deformity' or the 'aubergine sign.' Bleeding per urethra, hematuria, or urinary retention might occur, which indicate a urethral injury.[1,4]

Ultrasonogram may corroborate the clinical findings. High frequency probes easily pick up tunica albuginea defects and hematomas. Cavernosography and MRI may be done when the clinical diagnosis cannot be reached, but not at the cost of surgical delay. Retrograde urethrogram and flexible cystoscopy may help in cases with suspected urethral injuries.[1,4-6]

Earliest surgical exploration is the current treatment of choice with subcoronal circumcising incision being preferred by most authors as it allows complete exposure of all corporal bodies along the entire shaft. Tunical tears should be repaired with absorbable continuous interlocking or interrupted suture with buried knots. Non-absorbable sutures promote scar formation and should be avoided. Spongiosal injuries, if present, should be repaired at the same time. Surgical intervention is reported to be safe with restoration of erectile function comparable to controls and a high patient and partner satisfaction levels.[1,2,7,8]

Though the physical findings in our case were non-contributory and the patient achieved a normal erection following the initial episode, possibly due to the location of the rent, which is unlike that reported in literature, the typical history supporting the diagnosis of a penile fracture prompted us to opt for a surgical exploration, even though ultrasound findings were not definitive.

CONCLUSION

A typical history, even without physical findings and imaging, warrants a high index of suspicion and should prompt an immediate surgical exploration in suspected penile fractures.

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