

# FRACTURED PENIS : TWO CASE REPORTS

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## SUMMARY

*Fractured penis has traumatic consequences on the patient as both his manhood and procreation ability are threatened. 2 cases of fractured penis successfully treated at the Armed Forces Hospital, Terendak, Melaka by a combination of surgical intervention and splintage are reported and the management discussed.*

## INTRODUCTION

Fracture of the penis is an uncommon injury resulting from a direct blow to the erect penis. The nature of injury will be enlightened subsequently. The injury is rather easy to recognise but easily missed and the treatment has remained controversial. This article attempts to highlight the management of two cases of fractured penis presented at the Surgical Department, 94 Armed Forces Hospital, Terendak, Melaka. The treatment is unique as it involved both surgical intervention and splintage of the shaft of the penis. Previously-reported cases were either managed surgically or conservatively by splintage alone. In our experience, one case was treated in 1984 while the other was seen in 1985.

## CASE HISTORY

### Incidence

The real incidence of the injury is unknown as the literature is scanty. Presently, there are only about 110 cases of rupture of the corpus cavernosum in the world literature of which the English literature reported 60 cases.

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## Aetiology

Rupture occurs during sexual intercourse, when the penis slips out and is thrust against the symphysis pubis or against the perineum.

Secondly it may be due to abnormal bending of the penis during masturbation; or trying to place an erect penis in a tight pair of pants.

Lastly, it may be due to a direct trauma, including rolling over in bed or being kicked by a horse.

## Pathophysiology

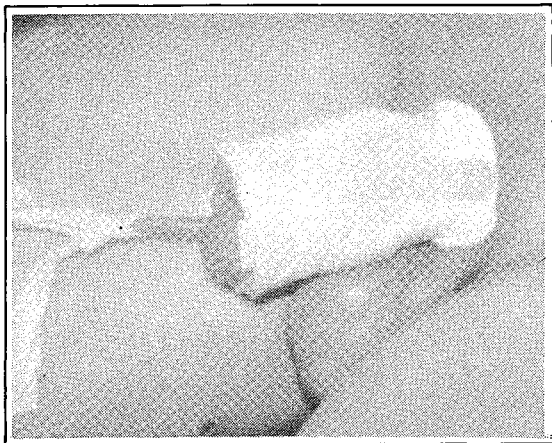
The pathological lesion is a tear of the tunica albuginea of a corpus or rarely both corpora resulting in haematoma formation; swelling and skin discolouration. Rupture occurs only when the erect penis is subjected to a direct external force. During erection, the tunica albuginea thins and becomes more susceptible to injury.

## Case 1

In April 1984, a newly-married Chinese cook, aged 22 was referred to the Surgical Outpatient Department. Earlier, the patient had consulted several private practitioners and was clinically diagnosed as a case of cancer of the penis.

On initial examination, the penile shaft was found to be curved to the left with a small swelling on the right side of the shaft. The swelling was tense, cystic and non-tender. There was no history of exposure to venereal disease or urethral discharge. During questioning, the patient admitted that he had been rather 'vigorous' during sexual intercourse. In one such act, the patient suddenly felt a severe excruciating pain along the shaft of his penis, but this did not hinder him from completing the act!

The patient was duly admitted and exploration of



**Fig. 1 Postoperative management by splintage following surgical decompression.**

the swelling was done under general anaesthesia. He was found to have discontinuity of the right corpora cavernosum with a pocket of pus secondary to a haematoma.

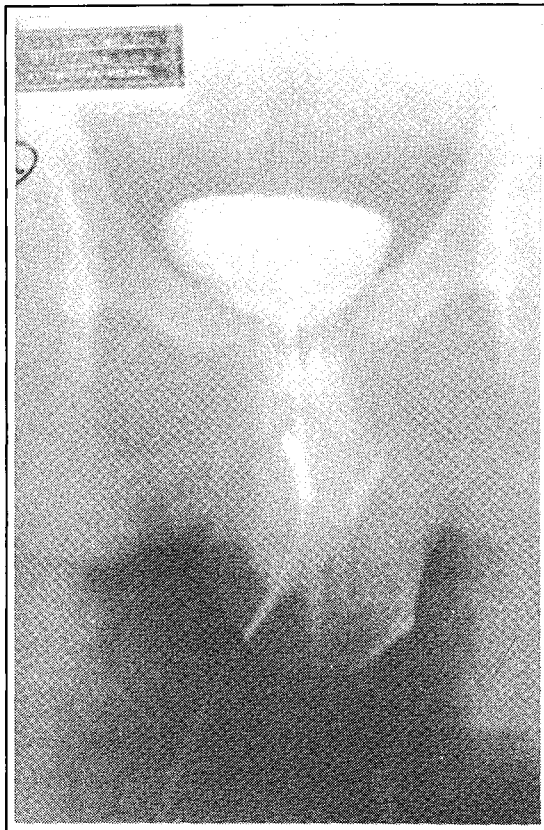
Decompression of the haematoma and evacuation of the pus were done, followed by trimming of the edges of the raw wound. The right corpora cavernosum was sutured with chromic catgut and polyglycolic acid sutures. The patient was catheterized with a size 20F Foley catheter which was strapped and anchored tightly to the thigh. The penile shaft was immobilised by splinting with wooden spatulas on both sides (Fig. 1).

Post-operatively, the patient was maintained on tablet stilboestrol 5 mg tds for a week with an appropriate antibiotic cover. The penis was splinted for about 10 days and a urethrogram was done after three weeks to exclude fistulous communication (Fig. 2). Follow-up revealed that the patient regained complete penile function, as he announced his wife was pregnant on his third follow-up, three months after discharge.

## Case 2

The second patient, an Indian aged 53, a retired Army personnel, was admitted to the Surgical Ward, 94 Armed Forces Hospital, Terendak, with complaints of painful erection and deviation of his penile shaft to the left. In addition, an increase over and above the size of the erected penis was apparent following erection. He underwent decompression of swelling and penile splintage, based on the clinical diagnosis of fractured penis (Fig. 4). A histopathology report of the wound edges confirmed the presence of fibro-muscular tissue. The normal regimen as in Case 1 followed.

The patient was discharged after two weeks with the ability to achieve normal erection and sexual function. Subsequent reviews confirmed that the patient is



**Fig. 2 Postoperative urethrogram.**

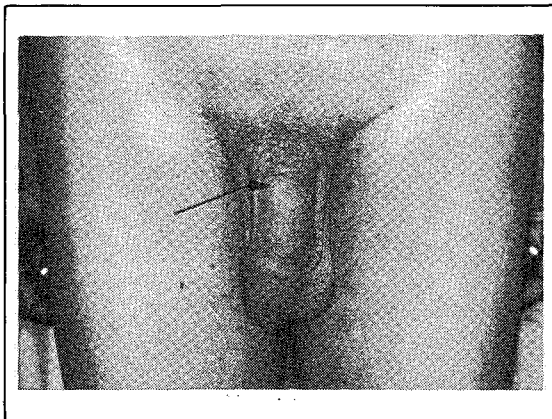
presently enjoying a normal life. The second case illustrates failure of an early intervention thus leading to fibrosis, as reported by the HPE report.

## Management

The word 'fracture' conjures up an image of a break in the continuity of bone which may be complete or partial. Hence the term 'fractured penis' may well be considered a misnomer as the penis is entirely soft tissue. However fractured penis is a recognised entity, which although uncommon is sometimes quite difficult to treat successfully. The two cases mentioned earlier were managed in Terendak by the following regimen: clinical diagnosis; surgical decompression; repair of the ruptured corpora cavernosum with chromic catgut and polyglycolic acid sutures; internal splintage with a 20F Foley catheter strapped to the thigh; external splintage with spatula and strapping; oestrogen therapy for about a week to avoid erection; sedation to reduce anxiety.

## DISCUSSION

The incidence of fractured penis is rather uncommon and most cases are either treated surgically or by splintage.



**Fig. 3 Fibrous swelling.**

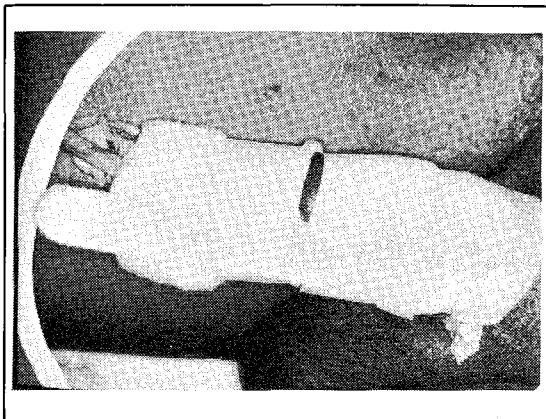
Three reported cases of fractured penis were published by two Sudanese workers using a non-surgical technique with splintage, of which one was lost to follow-up.

Badenock's approach included elevation of the penis on the abdominal wall and applying cold compression.

The work of Nicolassen *et. al.*, based on his seven cases consisted of immediate exploration, identification, sharp debridement and primary repair of the tear with absorbable sutures and indwelling catheter with a Coban pressure dressing for about two days.

## CONCLUSION

This article reports similar experiences in 94 Armed Forces Hospital, Terendak. Two cases were successfully treated by a combination of surgical intervention and splinting. Both patients regained normal sexual function after discharge from hospital.



**Fig. 4 Postoperative splintage.**

## REFERENCES

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