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Letter to the Editor

Surgical treatment of penile fracture

Dear Editor,

We read with interest the paper by Gedik A et al.[1] on penile fracture. It was noteworthy that while they could identify and "palpate the rupture" in 83 of the 107 patients they still elected to do a subcoronal circular (degloving) incision in 87 cases and a direct approach via a semicircular incision in only 14 cases. Although they reported excellent results with "no early postoperative complications", many authors have documented complication rates as high as 60% with skin necrosis, wound infection and hematoma formation.[2,3] Asgari et al.[4] made a circular subcoronal incision in all their 68 cases and always found the tear in the proximal third of the corpus cavernosum. In fact, it is well recognised that the tear is usually unilateral, traverse and proximal to mid corpus cavernosum. Thus, the circum-annular degloving incision will incise and dissect a lot of edematous, hemorrhagic tissue, blood vessels and nerves to find a 1-3 cm unilateral tear in the tunica albuginea.[3] If therefore, the authors could have identified the rupture site in 83 cases, they could have approached it directly. This could have been done under local anesthesia, as it involves minimal dissection and little trauma to blood vessels, nerves, skin and subcutaneous tissue. Moreover, if the fracture site could not be accurately identified initially, a delay of 7-12 days (as an outpatient) will allow the edema to subside and the fracture site would become very obvious by the 'rolling sign' permitting direct repair under LA as a same day procedure, even via a penis-scrotal incision.[5] We believe that subcoronal degloving incision should be reserved for those complex cases such as bilateral carvenosal tears complete urethral disruption while simple duct repair be utilised for very common, unilateral cavernosal rupture.

Vijay Naraynsingh, M.D.

Ravi Maharaj, M.D.

Dilip Dan, M.D.

Seetharaman Hariharan, M.D.

Department of Clinical Surgical Sciences,
The University of the West Indies,
St. Augustine Campus
Trinidad & Tobago, West Indies

e-mail: *uwi.hariharan@gmail.com*

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Author's response

Dear Editor,

We read the interesting letter of Dr. Naraynsingh et al. and we replied their comments in the fallowing letter. We would like to thank them all for reading our article.

Yes we could palpate the rupture in 83 of 107 patients. We try to palpate the rupture only for diagnosis not for to decide the type of incision. They also right by declaring that the cavernosal rupture is generally unilateral. But we always prefer to do the subcoronal degloving incision because it is well known that in 38% of penile fractures there is an adjacent urethral rupture.[1] With a direct incision over rupture it is not possible to examine the corpus spongiosum so any adjacent ruptures could be missed easily. Also if there is a deep dorsal vein rupture without corporeal injury also this will be missed. Direct incision over rupture could only be preferred in cases if MRI is done for diagnosis.[2] But there is no study reporting that MRI should be the must in cases of penile fracture for diagnosis. Another advantage of subcoronal incision is about the wound healing; scarring in longitudinal incision is seen more frequent than subcoronal incision. We didn't accept the edema and hematoma as an early postoperative complication as there is edema and hematoma before the surgical procedure. Early postoperative complication rate is generally reported as 9%.[3] So 60% early postoperative complication rate is astonishing for us.

As seen in some of our patients late postoperative complication rates are increasing if the patient is treat-

ed conservatively or with a late surgical repair. So we do not advice to delaye the surgical repair to palpate the rupture, in cases where the rupture could not be palpated during early period. Fibrosis or curvature can be seen in 35% of these cases.[4] So we always prefer and advice early surgical repair with subcoronal degloving incision.

Sincerely,

Abdullah Gedik, M.D.

Department of Urology,
Dicle University Faculty of Medicine,
Diyarbakır, Turkey.

e-mail: *abgedik@gmail.com*

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