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Self Inflicted Near- Total Amputation of Penis- A Case Report

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INTRODUCTION

Amputation of the penis is a rare condition reported from various parts of the world as isolated cases ; the common aetiology is self-mutilating sharp amputation or an avulsion or crush injury in an industrial accident. A complete reconstruction of all penile structures should be attempted in one stage which provides the best chance for full rehabilitation of the patient. We report here a single case of near-total amputation of the penis, which was successfully reconstructed.

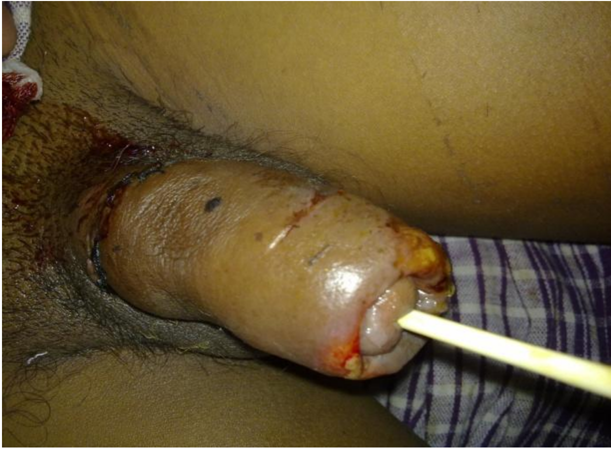
CASE REPORT

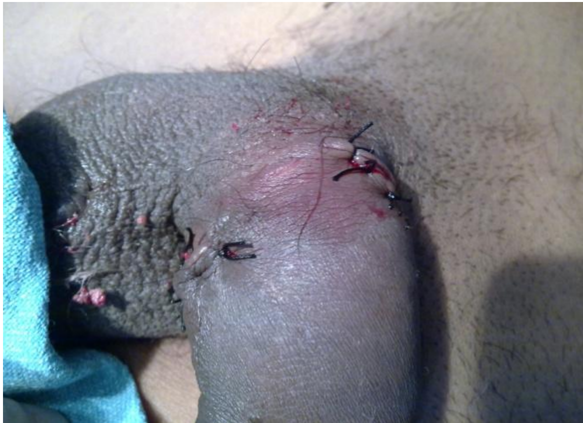
In October 2010, a 40 year-old married male presented to the casualty department with near-total amputation of his penis following self infliction. He is in antidepressants drug.

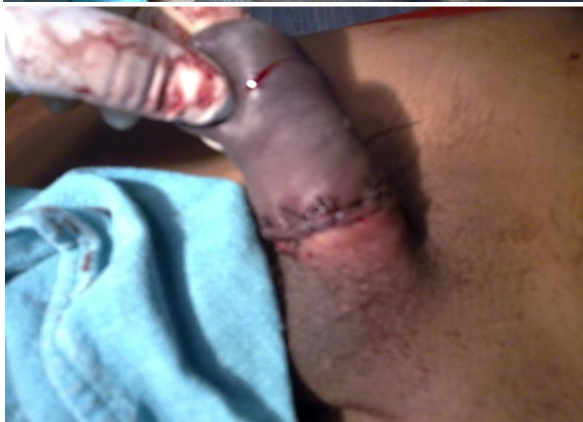
On examination, penis was found to be amputated about 2cm distal from the base of penis. Approximately whole circumference of skin and dartas along with corpora cavernosa, corpus spongiosum and urethra were completely transacted except for a part of skin and dartus ventraly. The scrotum with its testicles was found to be intact. Bleeding from the penile stump was stopped with the help of a pressure dressing.

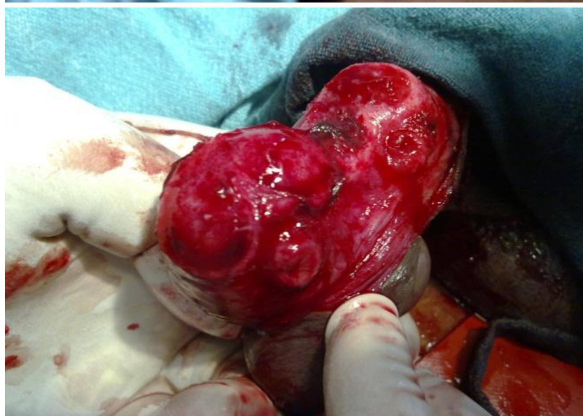
PROCEDURE

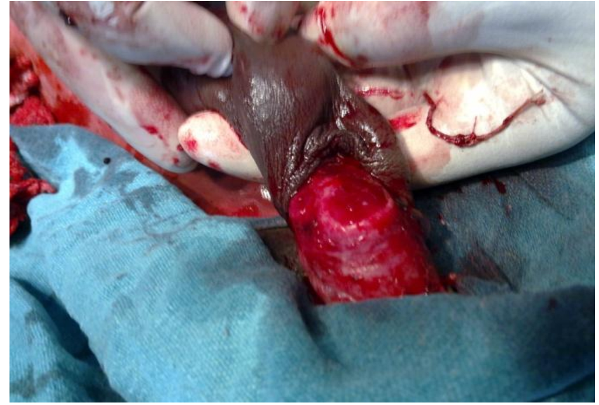
Patient was shifted to the operation theatre and under proper antiseptic precaution wound was cleaned with normal saline along with removal of haematoma. The penile urethra was reanastomosed interrupted with 3-0, vicryl on Foleys catheter. Corpora cavernosa and corpus spongiosum were reconstructed by interrupted suture with 2-0, vicryl and skin was sutured with 2-0 mersilk. The whole procedure lasted for one hour. Loose dressings with supports kept the penis elevated. Postoperative adjunctive measures were adequate hydration, antibiotic and sedative. Monitoring was done by assessing colour, temperature and bleeding on pin prick .After 24hrs dressing was removed and on pin prick fresh blood ooze out through prepuce and glans penis. Skin was found dusky. Stitched were removed on 8th postoperative day. Foleys catheter was removed after 3 weeks with good urine flow from the external urethral meatus.

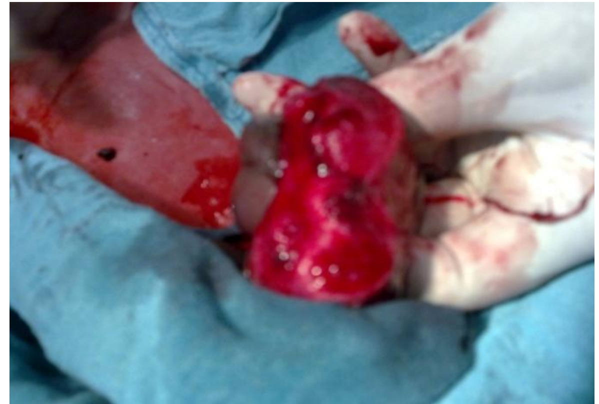












DISCUSSION

Penile amputation is an uncommon injury. 87% of the patients reported had psychiatric problems. Self-amputation of external genitals is also known as Klingsor syndrome. In 1970 in Thailand, an epidemic was seen, of penile amputation as punishment for philandering by humiliated wives. The first documented case of macroscopic penile replantation was reported in 1929 by Ehrlich. Cohen *et al,* reported the first micro vascular replantation of penis in 1977.

The factor responsible for success of reimplantation is early intervention in the form of urethral reanastomosis and attachment of corpora cavernosa and spongiosum. Another factor responsible was the regular postoperative monitoring of reimplantation and proper antiseptic dressing.

RESULT

The outcome of reimplantation and urethral reanastomosis was adequate for normal integrity of penile shaft with good patient acceptability and micturation function. The recovery of penile sensations was good.

CONCLUSION

The concept of doing urethral reanastomosis and attachment of corpora cavernosa and spongiosum for near-total penile amputation is best prospects for cosmetic restoration, physiological micturition and preservation of sensation .This procedure is easier and can be performed by general surgeons. Though micro vascular reimplantaion is the best procedure for penile amputation but this procedure can be done by general surgeon if the facility is not available.

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