Reimplantation of a traumatically amputated penis

A H M P Anuruddha¹, C T R Kasturi¹, P K Ravindran², B Lalith Perera³ and Anuruddha M Abeygunasekera⁴

Case report

A 42-year old divorcee, who had remarried, had to pay monthly alimony to his former wife. When he visited her to pay alimony she coaxed him to have sexual intercourse with her. When he was about to have intercourse she pulled out a knife and severed his erect penis. Five hours after the injury he reached the hospital. He was in haemorrhagic shock and his penis was connected to the body only through a narrow strip of skin (figure 1a).

After resuscitation, under general anesthesia the penis was cleansed with normal saline and a solution containing gentamicin. Cut ends of the urethra were anastomosed with 3/0 polyglactin sutures across a 14 Fr Foley catheter. Tunica albuginea was approximated with 3/0 polyglactin sutures. Cut ends of the dorsal arteries and veins of penis had been retracted. Only the left dorsal artery and vein were anastomosed with 6/0 polypropylene after flushing with heparin. Repair of the dorsal nerve of the penis was not attempted as a part of it was missing. Bucks fascia was approximated with 3/0 polyglactin sutures. Diathermy was not used to achieve haemostasis. An infusion of heparin was continued for 48 hours post-operatively and antibiotics were given for one week.

Figure 1a

Figure 1b

The traumatically amputated penis before (figure 1a) and three months after (figure 1b) surgery

After 3 months pain and crude touch sensations were present in the glans penis (figure 1b). He experienced erections but not adequate to have enjoyable sex. Treatment with sildenafil improved the erections for regular sexual intercourse.

Discussion

Historically traumatic amputation of the penis was often self-inflicted, usually during an acute mental crisis or by accident [1]. During the last few decades violent attacks by angry women against philandering partners have become a common cause of traumatic amputation of the penis [2].

If the patient presents acutely with the amputated distal part of the penis microvascular reimplantation is the favoured approach [3]. However, the patient's condition or other circumstances may prevent his transfer for microvascular reimplantation, and reimplantation should be carried out in the regional surgical units with the available resources. Then the established technique is primary anastomosis of the severed penis and burying it into the scrotum [1, 2] followed by a second stage removal from the scrotum. Primary anastomosis alone without burial into the scrotum can lead to necrosis of the penile skin and glans [2]. If there is a skin strip left as a connecting bridge burial of the penis into the scrotum is not necessary, as in this patient.

References

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¹Surgical Registrar, ²Senior Surgical Registrar, ³General Surgeon, ⁴Urological Surgeon, Karapitiya Teaching Hospital, Galle, Sri Lanka.

Correspondence: AMA, e-mail: <amabey@sltnet.lk>. Received 19 February and accepted 26 May 2007. Competing interests: none declared.