

Penile Constriction Devices – 3 Cases Experience

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Abstract:

Penile constriction devices are a rare but challenging clinical entity in urologic practice. they are applied for myriad reasons and depends on the age group. In adult and elderly males, they are applied to enhance sexual experience, in adolescent and young males they are applied as a part of sexual curiosity. Here we present a series of 3 cases with penile constriction devices. A 24 years old male patient presenting after 5 days with a metallic bolt over his penis, with distal edema and discoloration. Bolt was cut with a motorized rotating saw and decompression was done. A 57 years old man with rubber band applied to the base of penis, rubber band was cut and patient managed conservatively. And a 51 years old male with metal ring applied to penile base before sexual intercourse, ring cut with rotating saw and penile congestion was relieved. All the cases were managed conservatively without any adverse sequelae.

Key words: penile constriction; decompression

Introduction:

Penile constriction devices are a rare but challenging clinical entity in urologic practice. They are applied for myriad reasons which vary with the age group. In adult and elderly males, they are applied to enhance sexual experience, in adolescent and young males they are applied as a part of sexual curiosity.

Case Presentation

Case 1:

A 24-year-old male presented to the emergency department with complaints of penile pain and swelling. He stated that 5 days prior, after watching pornographic videos, he had placed a large metal bolt over his penis to increase penile length and to enhance his sexual experience. Following this he had fallen asleep with the metal bolt on and after waking up in the morning, around 8 – 10 hours later, he could not remove the bolt. He had noted increased swelling and pain over the swelling over the penis.

Out of embarrassment, patient did not seek medical attention for 5 days. Examination revealed a stainless-steel bolt over his penis at the proximal aspect. Distal penile stump was edematous with congested appearance (Figure 1). Mild blackish discoloration of the skin was present with dusky appearance. He was able to void with only minimal difficulty, urinary bladder was not palpable. Patient was posted for surgery under spinal anesthesia. A tongue depressor was placed under the bolt. Dorsal slit was given to decompress subcutaneous edema and to glide out the bolt. But these attempts failed. So, decision was taken to cut the metal bolt. Metal bolt was cut with a motorized circular saw (Dremmel rotating saw) (Figure 2,3) at diagonally opposite points into two halves. Tongue depressor kept under the bolt to protect penile shaft from saw-tooth injury. Damp towels were placed on the exposed skin to protect it from flying sparks. Continuous ice water irrigation was used during sawing to lower the temperature and avoid thermal injuries to skin and penis. Skin and soft tissues under the bolt area was debrided up to buck's fascia. Skin closed primarily with 3-0 Monocryl sutures.



Figure 1: Photograph showing the metal bolt at the base of the penis.



Figure 2: Image showing Dremmel rotating saw being used to cut the metal bolt at the base of the penis.



Figure 3: Image showing the metal bolt cut into two pieces and then removed from the base of the penis.

Case 2:

A 57 years old gentleman presented with rubber band applied to the base of the glans penis for sexual pleasure. Patient presented 1 day after application of the band (Figure 4). Patient tried to cut the band, but failed due to oedema Patient had engorged semirigid distal penis with oedema, with no cyanotic skin changes or any difficulty micturition. Rubber band was cut and with conservative management oedema resolved without any loss in erectile function.



Figure 4: Image showing rubber band trapped at the base of glans penis.

Case 3:

A 51 years old man presented to emergency department with metal ring applied to the base of penis before sexual intercourse for sexual enhancement. Patient failed to remove the ring post-coitus, and presented 16-18 hrs with penile swelling and pain. Patient had mild difficulty micturition. Ring was cut with a motorized circular saw. Skin ulceration was present under the metal ring, managed conservatively with dressings (Figure 5).



Figure 5: Image showing metal ring applied at the base of penis.

Discussion:

Penile strangulation is an unusual clinical condition that was first reported in 1755 by Gauthier Penile strangulation with constriction devices can have serious sequelae if it is not treated emergently [2]. Usually patients have delayed presentation, once patient is exhausted with all the home remedies and pain and swelling starts to appear, 5 days in our case. patients present late due to Embarrassment and associated social stigmata, which can have clinical implications. Strangulation can cause vascular compromise with ischemia of skin, loss of penile sensation, skin necrosis and ulcerations, sepsis, urethral injuries, urethro-cutaneous fistula formation, gangrene or even autoamputation of penis. In 1991, Bhat *et al.* presented an excellent original classification for penile incarceration composed of five grades from only distal oedema as follows: [3]

- Grade I: Distal oedema only
- Grade II: Distal oedema, skin and urethral trauma, corpus spongiosum compression, decreased penile sensation
- Grade III: Skin and urethral trauma, no distalsensation
- Grade IV: Separation of corpus spongiosum, urethral fistula, corpus cavernosum compression, no distal sensation

- Grade V: Gangrene, necrosis, or distal penile amputation. Silberstein *et al.*, developed a grading system with two broad categories as low- and high-grade penile injuries, with high grade injuries as those requiring secondary surgical intervention after removal of the strangulating object [4]. The type of constricting device appeared to impact the degree of penile injury, with the more severe injuries occurring from non-metallic devices [4]. Chronic use of constriction devices may result in lymph stasis and long-term lymph oedema mimicking elephantiasis [5]. There are many methods for removing thick, hardened strangulating materials, including aspiration of the corpora or the use of saws, grinders, dental drills, and the string method, degloving or amputation of penis [6].

Conclusion:

Though a rare clinical presentation in urologic practice, penile strangulating devices needs urgent decompression to prevent long term sequelae.

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