



Case Report

Penile prosthesis implantation after paraffinoma excision

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urothelial cancer**Abstract**

This case report presents an erectile dysfunctional man who requested implantation treatment after paraffinoma excision and reconstruction with scrotal flap. Our special concern was that the deformed anatomy and thick scar might cause unusual events during surgery, resulting in an unsatisfactory outcome.

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Introduction

One reason for seeking penile enlargement may be from penile dysmorphism by, ie, underestimating one's own penis size while overestimating the average penis size. Another reason is that some men may want a larger penis to enhance their sex lives, even if their penis is average or above average in size already. Many legal and illegal techniques have been tried. Injections with mineral oils, liquid silicone, or paraffin may give devastating results. Treatment often requires extensive penile reconstructive surgery which involves complete excision of foreign bodies along with the associated reaction followed by primary closure if possible¹.

First introduced in 1973, penile prosthesis is the gold standard for erectile dysfunction (ED) for medically refractory ED. Ongoing advancements have greatly improved all outcome measurements, with contemporary studies reporting consistently high satisfaction and lower complication rates. Prosthesis implantation after paraffinoma excision is reported.

Case Report

Penile augmentation with mineral oils, paraffin or liquid silicone is common in Thailand, due to a lack of knowledge and sequelae². A granulomatous reaction causes tumor like deformity. This results in inflammation, pain, and loss of elasticity of the prepuce skin. The swelling also begins to extend into the suprapubic region at the base of the penis, which is also tender.

A 54-year-old man with poor control of diabetes and ischemic heart disease status post percutaneous coronary intervention was injected with mineral oils for the purpose of penile augmentation for 2 years. He presented with pain and a deformed penis. Furthermore, he also had erectile dysfunction grade I which did not respond to PDE-5 inhibitors, although he still had sexual desire.

General physical examination was normal. The entire penile skin was indurated with ulcerations. There was no residual normal penile skin. The suprapubic

mass at the base of the penis measured about 5 cm. However, both testes and scrotal skin were uninvolved. Routine laboratory investigations were normal. There was no contraindication for surgery.

The patient's first desire was to remove the indurated skin and pain relief. The operative plan was to remove all indurated prepuce and mass at the suprapubic area. Scrotal skin flap was designed to cover the penile shaft. Tension at the suprapubic area was relieved with V-Y flap. The operation was a success without unusual event.

On follow-up the patient was satisfied with the result but requested a solution for erectile dysfunction issues, due to poor vascular status and relative contraindication for PDE5 inhibitor. We offered him the penile prosthesis implant. After a discussion about general considerations concerning the implant: Types of implant, preparation for the procedure, advantages and disadvantages, he elected to have the surgery. Due to penile and suprapubic scar, we recommended a malleable implant. The most concerning issue was about the scarred tissue, which could possibly retract, causing the penis not to move into the upright position after implantation.

The operation was executed 1 month after the paraffinoma excision. Pre-operative preparation followed implantation guidelines. Prophylaxis antibiotics were injected (Amoxiklav and Cephalosporin). Scrotal wash and shower with Chlorhexidine. Hair was clipped. Operative field was painted with Duraprep[®] and draped with Ioban[®]. Foley catheter was indwelled. Subcoronal approach was chosen due to the thick scrotal scar. After the incision was made, dissection continued to identify corporal bodies. Due to the thick scrotal flap at the penile shaft, the urethra was accidentally torn. We noticed a small amount of blood per urethral meatus. To confirm, we pushed the NSS via meatus and noticed leakage from the incisional site. Incision was dissected wider to locate the urethral injury; 0.5 cm injury site was located and repaired. NSS was irrigated to confirm no leakage.

Dissection continued until the corporal body was identified without overlying dartos. After corporotomy was made, dilatation of the corpora was performed with Brooks dilators. Serial dilatation proximal and distal corpora without resistance were undertaken. Corporal was measured with Furlow dilator. After both corporas were dilated, NSS was irrigated proximally and distally to confirm no urethral injury. Brooks dilators was placed in both corporas simultaneously to confirm no crossover.

Total length was 18 cm and dilated to 14 mm diameter. We selected a Coloplast Genesis® 13 mm diameter and 17 cm length. Implants were placed into both corporas. Penis can become erect straight up, proving the rigidity and girth of the implant could overcome any tension from the scar. Corporotomies were closed. Subcutaneous tissue overlying was closed and the skin approximated.

He was admitted for a night and discharged

the next day with Foley catheter. Catheter was placed for 5 days (usually only one day but due to urethral injury). On the 5th day, he attended a clinic for follow-up; catheter was removed. There was no sign of infection. He was satisfied with the girth and rigidity.

Discussion

Penile prosthesis implantation in special circumstances requires a careful strategy. General care for implantation: remain infection free, maintain penile length and girth, and ongoing patient satisfaction. In this case, implanters must prepare for unusual events during the operation, and make correct decisions in order to achieve surgical goals. Aesthetic manipulations in the penis are becoming increasingly popular, and both its terminology and its medical implications should be known by urologists and andrologists³.



Figure 1. The genitalia before penile prosthesis implantation.



Figure 2. The genitalia after penile prosthesis implantation.

Conflict of interest

The authors declare no conflict of interest.

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