

Penile Carcinoma - An Uncommon Presentation

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Abstract: *The penile carcinoma is a rare uncommon presentation. We here are reporting such a case in a 65 years old male presenting with a fungating mass covering whole of the penile shaft for which total penile amputation with bilateral orchidectomy with urethral reconstruction was done.*

Keywords: penile carcinoma- an uncommon presentation

1. Introduction

Penile cancer is uncommon but when it is diagnosed it is psychologically devastating to the patient. Benign, premalignant and malignant conditions can be differentiated. Penile squamous cell carcinoma the most common penile malignancy, behaves similarly to the squamous cell carcinoma in other parts of the skin. Metastasis, which occurs with this type of carcinoma when the diagnosis or the treatment is delayed, is usually lethal. This is slow growing cancer in early stages, because it seldom interferes with voiding or erectile function, patients do not complain until pain or discharge from the cancer occurs. By this time, the cancer has usually progressed from being superficial to invasive. We report a case of penile carcinoma diagnosed as squamous cell carcinoma after total penile amputation.

2. Case Report

65 years old male presented with complain of swelling with fungating growth over penis since 3 months. He had no any history of weight loss, nausea or vomiting. Patient had a history of something bite 3months back. Since then there was a small growth on the posterior wall which gradually increased to the present size and involving the whole of the penile shaft. Patient is a known case of type 2 diabetes mellitus since 18-19 years on T.metformin + glimiperide 1-0-1. On examination patient was well built with no any signs symptoms of anaemia. On local examination fungating growth was seen involving whole of the penile shaft with foul smell with urethral opening not very well appreciated with mild discharge with bilateral testis normal and no any palpable inguinal lymphnodes.

On investigating the patient, all blood reports were normal. Ultrasonography performed which was suggestive of few variable sized lymphnodes noted at bilateral inguinal region

with loss of fatty hilum, few of them appears necrotic, largest measuring 1 x 1 cm in right inguinal region. CT scan of the patient was suggestive of heterogeneously enhancing soft tissue thickening of maximum thickness 32 mm noted involving penis which infiltrates both corpora cavernosa and corpus spongiosum with multiple variable sized enhancing lymphnodes noted involving bilateral inguinal region largest of size 1.4 x 1.2 cm involving right inguinal region.

Per urethral catheterisation was tried but was not possible as the opening of urethra was under the fungating mass, so an infant feeding tube was inserted and fixed. Patient was then posted for the operation where total penile amputation with bilateral orchidectomy with urethroplasty was performed followed by which a 20 no silicon catheter was placed with 16 no negative suction drain in the subcutaneous plane and skin was the closed with prolene 2-0 followed sterile dressing was placed.

The specimen was then further sent for histopathological examination which was suggestive well differentiated usual keratinizing squamous cell carcinoma of penis (Tumour stage: pT1a). Gross examination of amputated part was showing a cauliflower like growth involving whole of the distal part of penis with size 9 x 6.5 x 6 cm, greyish white in colour and firm in consistency. On cut section of growth friable greyish white with areas of haemorrhage and necrosis seen. Sections of the tumour invade lamina propria of the glans and coronal sulcus (pT1a). Penile (distal) urethra: free from tumour. The resection proximal margin/ surgical margin (urethra, periurethral tissue, corpus cavernosum, buck's fascia at the penile shaft and skin): free from tumour. There is no lymphovascular invasion or perineural invasion. The right and the left testis are free from tumour.

Per operative images



Volume 9 Issue 2, February 2020

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Patient was seen in regular follow-up and suture removal was done after 14 days and after 21 days catheter was removed and patient was able to pass urine without any difficulty. After that patient was referred to radiotherapy department for further radiotherapy-chemotherapy treatment.

3. Discussion

Carcinoma of the penis is most typically a squamous cell carcinoma arising in the skin of the glans penis or the prepuce. It may be flat and infiltrating or warty in appearance. The former often starts as leucoplakia and the latter results from an existing papilloma. Local growth continues for months or years. T1 tumours are confined to the skin, with T2 tumours invading the corpus spongiosum or the corpus cavernosum. T3 tumours invade the urethra and T4 tumours invade adjacent structures. The earliest lymphatic spread is to the inguinal (N1 and N2 disease) and then to the iliac nodes (N3 disease) [1]. Many patients present late either because of embarrassment or because of misdiagnosis. About 10% of patients are under 40 years of age. By the time the patient presents, the growth is often large and secondary infection causes a foul, bloody discharge. There is typically little or no pain. Around 50% have inguinal lymph node enlargement at presentation but the nodal enlargement often reflects infection. In many, the prepuce is non-retractile and must be split to view the lesion. A biopsy should be performed to make the diagnosis. Untreated, the whole glans may be replaced by a fungating offensive mass. Later, the inguinal nodes can erode the skin of the groin. The management of the tumour includes excision of the mass with inguinal lymph nodes treated after a delay of 3 weeks following treatment of the primary tumour with either antibiotics or chemotherapy or radiotherapy [1]. As in our case there was a fungating mass we did the total penile amputation followed by after 3 weeks patient was referred to radiotherapy department for further radio-chemo treatment.

References

- [1] Bailey and love's short practice of surgery, 27th ed., 2018. 1492-1493.