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Case Report

Autoamputation of Penis Due to Advanced Carcinoma Penis- A Rare Case Report

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Abstract: Incidence of penile carcinoma is decreasing worldwide. Nevertheless, the incidence of penile carcinoma is still significant in tropical countries and often present with advanced stage and various complications. Penile carcinoma represents a difficult diagnostic and therapeutic issue to solve, mainly because of their psychological implications. Here we present a rare case of auto amputation of penis due to advanced penile carcinoma.
Keywords: penile carcinoma, therapeutic, psychological implications, penis

INTRODUCTION

Penile carcinoma is typically a disease of middle-aged to older men, most commonly affecting those between 50 and 70 years of age. Younger individuals are also affected; approximately 22% of patients are less than 40 years of age. In the Western world, the usual age at presentation is in the 6th decade [1].

The most important etiologic factor of penile cancer is the presence of an intact foreskin. Penile cancer is rarely seen in Jewish individuals, who are circumcised at birth [2]. In the United States, the risk of this disease in uncircumcised men is 3-fold higher than that of circumcised men and approaches the rate seen in some underdeveloped nations [3].

Penile cancer is one of the most common genitourinary cancers encountered in developing countries like India. The incidence of carcinoma of the penis varies according to circumcision practice, hygienic standard, phimosis, the number of sexual partners, HPV infection, exposure to tobacco products, and other factors.

Treatment depends on the staging and varies from laser surgery (Tis and Ta) to partial or total penis amputation (T2, T3, T4) with or without inguinal lymphadenectomy (nodal metastases or not) and radiotherapy/chemotherapy if needed [4, 5].

CASE REPORT

A 45-year-oldmale chronic smoker and alcoholic presented with neglected lesion over penis with micturition difficulty. Patient was apparently well 3 years back when he developed small lesion at the prepuce and dysuria. He had consulted a local doctor, for which circumcision was done.

But the lesion did not heal and grew in size to involve whole of the glans. Then, from one year the auto amputation of the penis was gradual and later he developed urinary obstruction from 6 months, for which suprapubiccystostomy was done by urologist and patient is being referred for further management.

On examination of genitalia, an exophytic, ill-defined mass with absence of penis with scrotal abscess was observed.

Fig-1: Autoamputed Penile Shaft Due to Carcinoma Penis

Fig-2: Autoamputed Penis with Scrotal Abscess

Chest X-Ray, USG abdomen was normal.

FNAC of bilateral inguinal lymph nodes reveals metastasis.

On CECT Pelvisheterogeneous mass lesion in peri-urethral region with bilateral lymphadenopathy was seen(Fig-3).

Histopathological examination reveals verrucous carcinoma penis (Fig-4).

Fig-3: Pelvic Image From Computed Tomography Scan

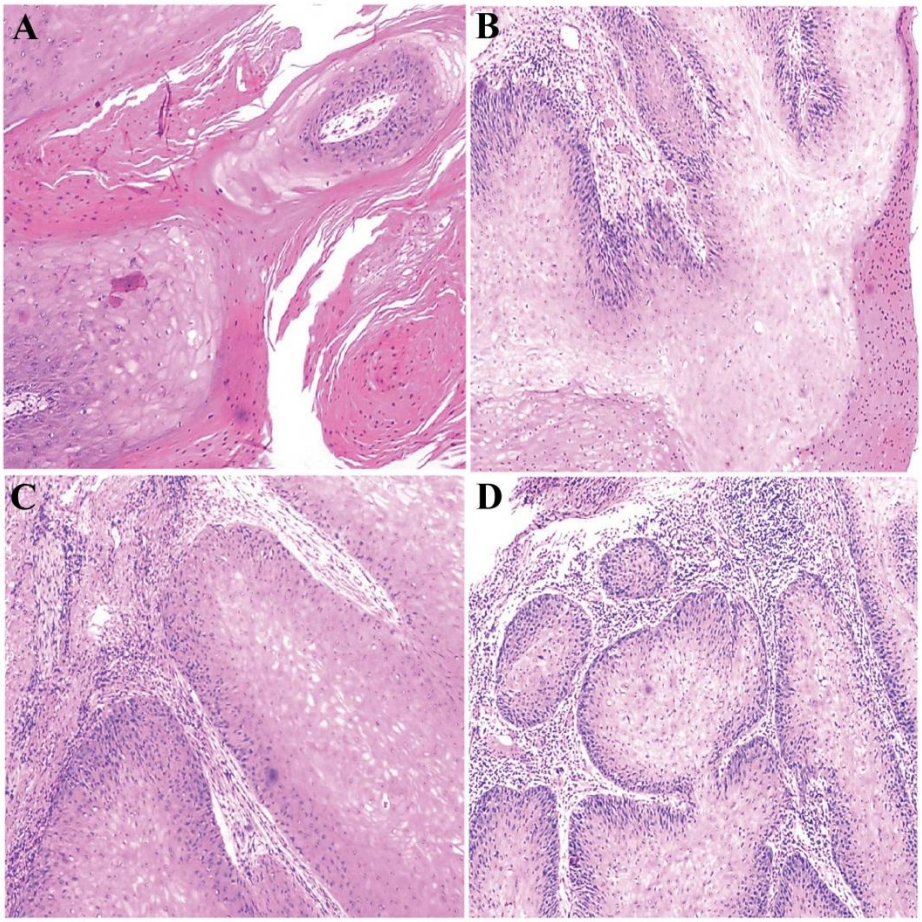

Fig-4: Histopathology View of Verrucous Carcinoma of Penis

MANAGEMENT

Our patient presented late in the course of disease because lack of awareness and social reasons. Definite treatment protocol for such patients with auto penectomy is unavailable and the tumour was infiltrating locally and was unresectable. Thus Primary Radiotherapy and Neo-adjuvant Chemotherapy was advised. Patient was advised for regular follow-up.

DISCUSSION

Majority of penile cancers are squamous cell cancers. It is locally aggressive and widespread disease is rare at presentation as the Bucks fascia acts as barrier to direct tumor spread. Primary excision is treatment modality of choice.

Organ preserving surgeries can be considered in patients with small superficial tumors whereas total amputation is the standard of care for large and invasive lesions. Ilioinguinallymphnode dissection is the standard treatment for metastasis to inguinal lymph nodes. Radio and chemotherapy usually have an adjuvant role, except for some cases. Irrespective of tumor stage, grade and treatment modalities, the average 3, 5, and 10-year survival rates are 59%, 52% and 32% respectively. But in untreated patients the survival rates fall sharply to around 6%.

Penile gangrene and subsequent auto amputation is known to develop in diabetics and end stage renal disease patients. The cause of penile auto amputation in advanced penile cancer could be vasculogenic due to blockade of end arteries with tumor emboli or direct tumor invasion. Most common presentation of penile cancer is as an ulcerative or exophytic lesion over glans penis or prepuce. Only less than 2% of patients present with an initial lesion on penile shaft, so even if the patient present in advanced stage of disease, auto amputation of penis is very rare.

Our patient presented late in the course of disease because lack of awareness and social reasons. Definite treatment protocol for such patients with auto penectomy is unavailable. if primary tumor is fixed to the underlying structures, the primary radiotherapy can be considered. Neo adjuvant chemotherapy with taxanes is recommended for patients with unresectable tumor or fixed enlarged lymph nodes.

CONCLUSION

Despite the diagnostic and therapeutic advancements and the fact that penile cancer is potentially curable, it is truly regrettable that such delayed presentation and poor follow-up with dismal prognosis continue to exist.

Only improvement in social awareness can lead to timely treatment of penile cancer to prevent the occurrence of such unfortunate cases.

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