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Peyronie's disease. Complete plaque exicision and autologous graft with anterior rectus fascia

Enfermedad de Peyronie. Escisión completa de la placa e injerto autólogo con fascia anterior de los rectos

Dear Editor,

We present the case of a 52-year-old male with a history of type 2 diabetes, arterial hypertension cerebrovascular transient ischemic attack, and erectile dysfunction treated with phosphodiesterase inhibitors. The patient consulted due to a two-year history of painful dorsal incurvation of the penis that had increased despite medical treatment with vitamin E and colchicine, and which practically impeded penetration. At exploration, a dense, fibrous plaque was palpated, located on the dorsal midline at the base of the penis, and measuring approximately 3 × 1.5 cm in size. The Kelami test was used to calculate the degrees of incurvation (45º), and penile ultrasound confirmed the diagnosis and size of the plaque. During surgery, and after artificial erection induction, we found the degree of incurvation to be somewhat greater (55º), and the size of the penis was moreover limited (12 cm in the erect state). Complete removal of the plaque was thus carried out with a cold scalpel, followed by autologous grafting with anterior rectus fascia and ventrolateral tunica albuginea plication (figs. 1 and 2). Posteriorly, a polypropylene mesh was placed to close the anterior fascia defect. Twelve months after surgery the patient had erections with phosphodiesterase inhibitors (which he previously also needed) and showed preserved sensitivity and minimum incurvation that did not complicate sexual intercourse.

Peyronie's disease is an infrequent condition probably resulting from penile traumatisms (though the etiology remains uncertain), giving rise to inflammation of the tunica albuginea and, ultimately, cicatrization and incurvation of the penis[1-3]. Initial treatment for the acute presentation of the disease is conservative, with vitamin E, colchicine, nonsteroidal antiinflammatory drugs, etc., being the most commonly prescribed drugs[2]. Surgery is generally reserved for those cases that fail to respond to conservative management, once the fibrotic process has stabilized, and in the case of patients with severe deformities of the penis that impede satisfactory sexual intercourse[4]. The surgical options vary according to the size of the plaque, the length of the penis,

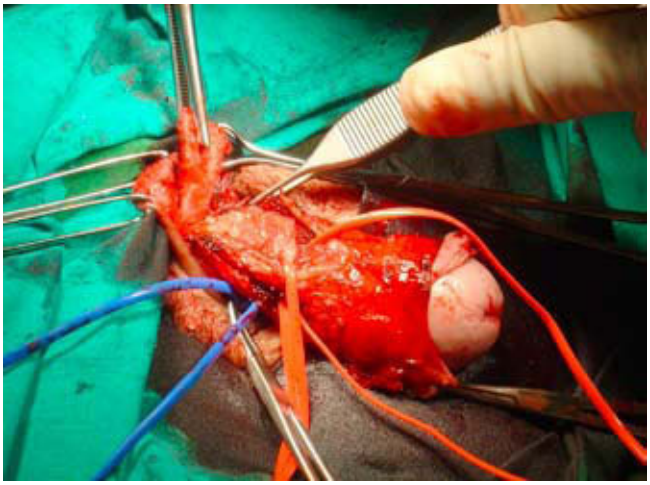

Figure 1 – Peyronie plaque removal using a cold scalpel.

Figure 2 – Grafting over the corpora cavernosa and fixation with two continuous vicryl 4/0 sutures.

the degree of incurvation, the concomitant presence or not of erectile dysfunction, etc. If the length of the penis is normal, with preserved sexual potency, and the deformity is mild or moderate (less than 50º), the Nesbit technique or plicature of the tunica albuginea suffices to correct the deformity and secure a functional penis. In contrast, in patients with large plaques, marked curvatures (over 50º), hourglass deformity, a short penis, distal flaccidity, or failure of previous surgery, plaque incision or excision is indicated, associated to the placement of a graft with or without penile prosthesis implantation — this approach being reserved for patients with erectile dysfunction unresponsive to medical therapy[4,5]. Many tissues of different origins have been used to correct the defect of the tunica albuginea after Peyronie plaque incision / excision, though no ideal material has yet been found. At present, the grafts can be classified as follows: a) autologous grafts (fascia lata, fascia temporalis, Buck fascia, tunica vaginalis, saphenous vein, dermis, dorsal rectus fascia, oral mucosa, etc.), which are the most widely used; b) heterologous grafts (porcine small bowel submucosa, bovine pericardium, etc.); and c) synthetic materials (Dacron®, Dexon®, Goretex®, etc.). The current tendency is to avoid the latter materials due to their antigenicity and inadequate functional properties[6,7]. The characteristics required of an ideal graft are histological similarity to the tunica albuginea, scant antigenicity, and resistance and elasticity to support erections. In addition, the graft must be easy to obtain and should be available in large sizes[6], since it is important for the graft to have at least 30% more surface than the defect to be covered, or else graft contraction will lead to repeat incurvation after surgery. The anterior rectus fascia exhibits the desired characteristics. On the other hand, the medical literature published to date, with long-term results, reports excellent clinical performance after using this graft[6,8,9]. In our case, on the basis of the existing reviews, and considering that we needed a graft size of approximately 5 × 3 cm, we chose an anterior rectus fascia graft.

Although most authors presently do not recommend complete removal of the plaque but only its incision - since full resection would require a large patch, which implies an increased risk of retraction, veno-occlusive failure and loss of erectile function — we consider it to be a good treatment option in selected cases. Regarding the anterior rectus fascia, we consider that it meets the criteria of an ideal graft, since it is morphologically and structurally similar to the tunica albuginea, and affords large patches, with scant added morbidity.

REFERENCES

1. Tunuguntia HS. Management of Peyronie's disease a review. World J Urol. 2001;19:244-50.
2. Rolle L, Tamagnone A, Bollito E, Ceruti C, Timpano M, Negro CL, et al. Could plaque excision surgery with graft induce a new fibrotic reaction in la Peyronie's disease patients? Arch Ital Urol Androl. 2007;79:167-9.
3. Chilton CP, Castle WM, Westwood CA, Pryor J. Factors associated in the aetiology of Peyronie's disease. Br J Urol. 1982;54:748-50.
4. Kendirci M, Hellstrom WJ. Critical analysis of surgery for Peyronie's disease. Curr Opin Urol. 2004;14:381-8.
5. Levine LA, Lenting EL. A surgical algorithm for treatment of Peyronie's disease. J Urol. 1997;158:2149-52.
6. Craatz S, Spanel-Borowski K, Begemann JF, Olianas R, Fisch M, Hohenfellner R. The dorsal lamina of the rectus sheath: a suitable grafting material for the penile tunica albuginea in Peyronie's disease? BJU Int. 2006;97:134-7.
7. Kadioglu A, Sanil O, Akman T, Ersay A, Guven S, Mammadov F. Graft materials in Peyronie's disease surgery: A comprehensive review. J Sex Med. 2007;4:581-95.
8. Kadioglu A, Sanil O, Akman T, Cakan M, Erol B, Mammadov F. Surgical treatment of Peyronie's disease: A single center experience with 145 patients. Eur Urol. 2008;53:432-9.
9. Pathak AS, Chang JH, Parekh AR, Aboseif SR. Use of rectus fascia graft for corporeal reconstruction during placement of penile implant. Urology. 2005;65:1198-201.

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Urethral prolapse in postmenopausical women

Prolapso de mucosa uretral en mujer posmenopáusica

Dear Editor,

Urethral prolapses are considered to be relatively infrequent. The are seen in two different age groups: prepuberal girls and postmenopausal women.

We present the case of a 74-year-old woman with a history of arterial hypertension and atrial fibrillation treated with Sintrom®. The patient reported to the emergency room of our hospital due to genital bleeding for the past few days. There were no micturition alterations. Exploration revealed