Reconstruction of Filarial Penis and Scrotum

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Elephantiasis of scrotum and penis is one of the most disabling condition. The problems in these cases are both functional and cosmatic. The excessive weight and bulk of the scrotum and penis and constant itching constitutes the great social embarrassment to the patient.

Management

All the cases in this series were investigated for microfilaria and it was found that more than 50% did not show the microfilaria even after repeated examination of blood smear. The diagnosis was mainly based on typical history. Routinely a course of medical treatment was given to all these cases before embarking on any surgical procedure.

The main aim of the surgical treatment in filarial scrotum and penis is to relieve the patient from the problems of difficulty in walking. Clothing and other physical activities like sexual relations due to the enormous weight and size of the scrotum and penis.

Surgical Procedure

A rubber Catheter is introduced in the bladder to avoid any injury to the urethra during dissection and also acts a drainage in the post-operative period.

Incision

The skin incision is made along the median raphe of the scrotum encircling the root of the penis and carried over the mid dorsal line upto the corona. The incision is now carried around the corona leaving a fringe of coronal skin.

Reduction of Scrotum

The skin of the scrotum is undermined on either side, thus creating a broad based pedicled flap on each side. The testes alongwith spermatic cord are isolated. The elephantiasic subcutaneous tissue is completely excised. Both the testes are now placed back in the scrotal cavity after complete haemostasis, and the scrotum is reconstructed after excising excess of thickened skin. Incision is closed with a drainage tube. The sac was not everted routinely unless the hydrocoele is also present.

Reduction of Penis

The thickened skin is excised from the body of the penis down to the tunica albuginea. In severe degrees of elephantiasis of penis, the glans penis is deeply invaginated and the care should be taken not to injure the glans, It is preferable to isolate the glans first by deepening the most distal skin incision carefully. Care should also be taken while excising the skin that corpus spongiosum is not injured, as it may cause a severe bleeding. The body of the penis is covered with

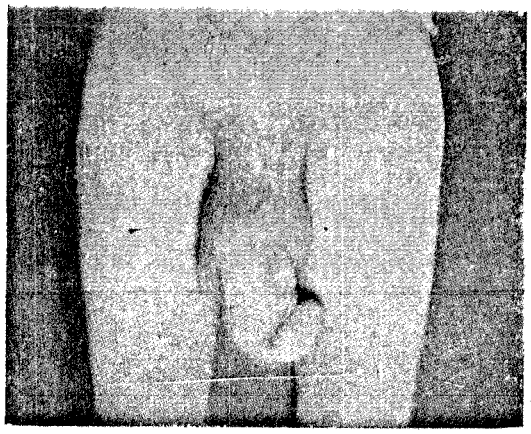

Fig. 1—Pre-operative condition of scrotum and penis.

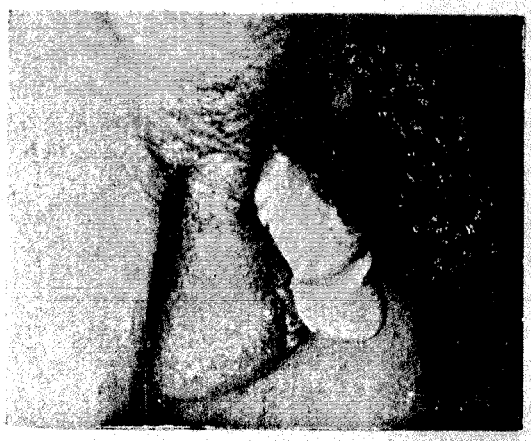

Fig. 2—Post-operative result after 1 year.

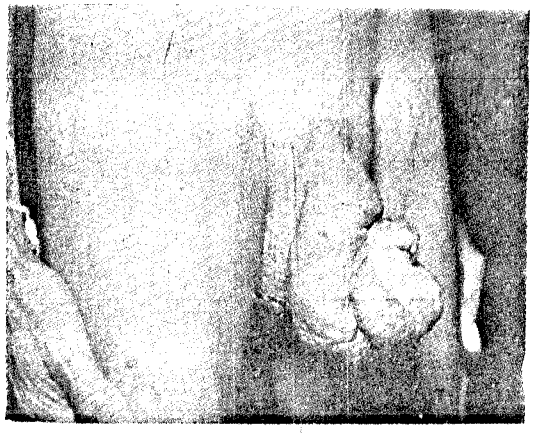

Fig. 3—Pre-operative condition of the penis. Size of the scrotum is normal.

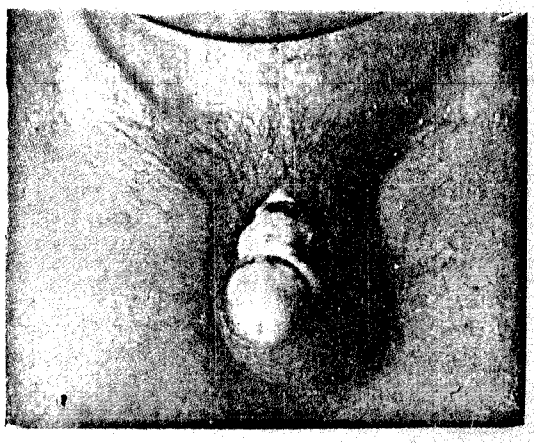

Fig. 4—Post-operative result after 1½ years.

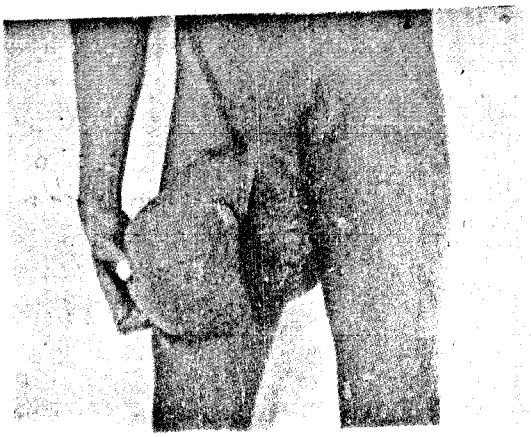

Fig. 5—Pre-operative photograph showing severe degree of lymphoedema penis.

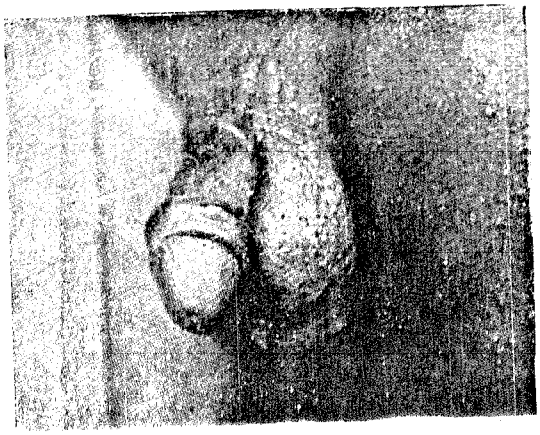

Fig. 6—Post-operative result after 6 months.

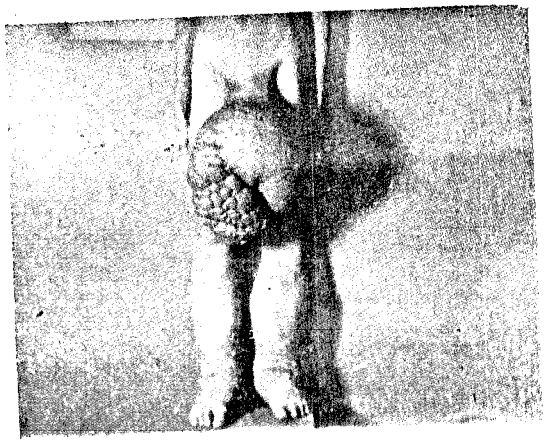

Fig. 7—Pre-operative condition of severe degree of

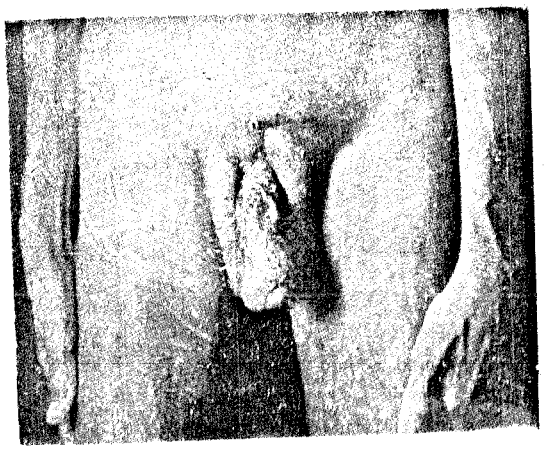

Fig. 8—Post-operative result after 6 months. Recurrence of slight oedema seen both in scrotum and penis.

medium thickness free skin graft which is stiched with the upper and lower margins of the wound, leaving alternate stiches long to act as a tie over dressings. The graft is covered with vaseline gauze and parafin wool and the dressings are maintained in position by tying the long threads over the wool. The dressings are further supplemented by bandage. In my opinion, bandaging and introduction of the catheter in the urethra gives sufficient splintage and immobilization of the graft.

The first dressing of the graft is done on 5th day and subsequent dressings are done depending on the condition of the graft. The scrotum is inspected on second day. Any collection is let out and drainage tube is removed. Stiches of the graft are removed on the 5th day and that of the scrotum on 7th day.

Results

Eight cases from mild to severe degrees of elephantiasis scrotum and penis have been treated by the above method. The postoperative period was uneventful. All the cases gave an excellent cosmatic and functional results. The patients were relieved of their social embarrassment due to the enormous weight and size of the scrotum and penis. Only in two cases a strip of skingraft, 2 cm. by 1 cm. was lost on the dorsum of the penis but the wounds healed without much scarring.

Out of eight cases only 6 patients came for the review after 1-2 years. Only one patient showed slight recurrence of oedema on the penis. All the patients were performing their normal sexual activities. In my opinion, the recurrence of the mild oedema is unavoidable, unless the organs are supported well and not allowed to hang against the gravity all the time.

Summary

Eight cases of mild to severe degrees of elephantiasis scrotum and penis have been treated. The procedure followed in the present series was total excision of the penile skin and free skin graft. Reduction of the scrotum by excising all the diseased subcutaneous tissue and reconstruction of the scrotum by scrotal flaps. The cosmatic and functional results have been presented. This procedure to reduce the size of scrotum and penis is most practical to relieve the patient from the great social embarrassment.

Acknowledgement

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