'website : www.ijacare.in e-ISSN No.: 2457-0443
INTERNATIONAL JOURNAL OF AYUSH CASE REPORTS (IJA-CARE)

A Rare Case of Penile Carcinoma- Clinical Images

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SHORT HISTORY:

A 37-year-old man came to the Shalya Tantra OPD, MGACHRC Wardha, with persistent complaints lasting two years. He had complaints of severe pain, swelling, pus discharge, a foul odor from the penis and scrotal area, along with burning during urination. The patient had a five-year history of type 2 diabetes Mellitus (T2DM), managed with medication, and no pertinent family medical background. Following evaluation, he was referred to an advanced medical facility, where he received a confirmed diagnosis of penile carcinoma on the basis of histopathological evaluation. Differential diagnoses considered included genital warts, balanitis, Peyronie's disease, syphilis, candidiasis, genital herpes, and balanoposthitis.

KEYWORDS- Genital growth, Penile Carcinoma, Pus Discharge, Urology.

Received: 03.06.2024 Revised: 11.06.2024 Accepted: 16.06.2024 Published: 26.06.2024

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DISCUSSION:

Penile cancer is very rare in USA and Europe; comprising 0.4–0.6% of male malignancies. However, it's a significant issue in developing nations, constituting up to 10% of male cancers in some of the African and South American countries. [1]. In India, rates vary from three per 100,000 in rural regions while 0.7- 2.3 per 100,000 in urban areas and, comprising over 6% of male cancers. [2] Jews report the lowest incidence. It affects older men but also occurs in younger men and children.

Causes: Penile carcinoma's cause are poor genital hygiene, phimosis [3], socioeconomic status, viral infections (like HPV), sexually transmitted diseases, Balanitis xerotica obliterans, tobacco use, and ultraviolet radiation exposure. Premalignant lesions such as cutaneous horn and penile intraepithelial neoplasia may evolve into squamous-cell carcinoma. The incidence of PC (penile cancer) varies with hygiene standards and cultural practices. Notably, circumcision significantly reduces its occurrence by 10

times.[4] HPV, particularly types 16 and 18, is strongly linked to penile carcinoma and penile intraepithelial neoplasia [5]. Despite associations with sexually transmitted diseases like chancroid, syphilis, and granuloma inguinale, their role in penile carcinoma remains uncertain. Ultraviolet radiation, especially in patients receiving PUVA therapy for psoriasis, increases the risk[6].

Figure -1: Before debridement

Figure -2: After debridement

Classification: Jackson classification [7]
Stage Description
Stage I : - Tumours confined to the glans penis, prepuce, or both of them
Stage II : - Tumours extending onto the shaft of penis
Stage III: - Tumours with operable inguinal metastases.
Stage IV: - Tumours involving adjacent structure near penile.

Treatment:
Management for Penile carcinoma primarily aims to completely remove the primary tumor. The gold standard is partial or total penectomy, but efforts focus on organ-sparing techniques like Mohs microsurgery, [8] laser surgery, or radiotherapy to reduce disfigurement. Partial penectomy with a tumor-free margin is sufficient for certain cases, while total penectomy is advisable for more extensive tumors or involvement of the scrotum.[9] Chemotherapy, though promising in advanced cases, lacks extensive data and requires further study. Radiotherapy, either external or brachytherapy, is also utilized, especially for young patients seeking organ preservation. However, it comes with complications and long-term side effects. Close monitoring is crucial for early detection of recurrence, especially after radiotherapy. Overall, the rarity of penile cancer in developed countries makes clinical trials challenging, with initiatives for research often spearheaded by developing nations with support from global health organizations and pharmaceutical companies.

Procedure: The patient was placed in the supine position, and the genital area was prepped and draped in the usual sterile fashion. Incision was made over the affected area at the base of the penis and,

with careful dissection performed to avoid damage to surrounding healthy tissue. Using a combination of sharp and blunt dissection, necrotic and non-viable tissue was meticulously debrided, ensuring clear margins where possible. Bleeding was controlled using electrocautery, with care taken to preserve as much healthy tissue as possible. The wound was thoroughly irrigated with sterile saline. Finally, a sterile dressing was applied to the wound site.

Outcome: The patient tolerated the procedure well. Complete debridement of the necrotic and tumorous tissue was achieved with clear margins noted on gross examination. Hemostasis was secured, and no immediate complications were observed. The patient was transferred to the recovery room in stable condition.

Consent of patient:

Consent was taken from the patient before starting the treatment protocol as well as prior to publication of the case details and data.

Conflict of interest: Author declares that there is no conflict of interest.

Guarantor*:* Corresponding author is guarantor of this article and its contents.

Source of support: None

How to cite this article:

Yadav Y, Asutkar S. A Rare Case of Penile Carcinoma- Clinical Images Int. J. AYUSH CaRe. 2024;8(2): 276-278.

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