

As pointed out by the authors MDCT will not identify all urothelial tumors due to either its peculiar location or small size or more frequently due to technical problems (lack of opacification of the pelvicalyceal system and ureter).

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## UROGENITAL TRAUMA

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### Management of penile fracture

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*J Trauma. 2004; 56: 1138-40*

**Background:** Penile fracture is not a frequent event. It consists of rupture of the tunica albuginea of the corpora cavernosa. Fracture occurs when the penis is erect, as the tunica is very thin and not flexible.

**Methods:** This prospective study was carried out over a period of 1 year and included 12 patients presenting with penile fracture.

**Results:** Diagnosis was made clinically, and there was no need to perform cavernosography in any case. The most common cause of fracture was trauma to the erect penis during intercourse. Mean age of patients was 29.5 (+/- 8.96) years, and mean time of presentation was 15.5 (+/- 8.04) hours. Subcoronal circumferential degloving incision was done in all cases. Nine patients were operated on, and three patients refused surgery and were treated conservatively. Repair consisted of evacuation of hematoma and repair of the tunical defect with absorbable sutures. The mean operative time was 33.9 (+/- 8.2) minutes. Preoperative and postoperative antibiotics were used, and all operated cases were discharged on the second postoperative day. All operated cases were able to achieve full erection with straight penis except one, in whom mild curvature and pain during erection was observed.

**Conclusion:** Penis fracture is a true urologic emergency. It should be treated surgically as early as possible to ensure a better outcome.

### Editorial Comment

This Egyptian study is a nice review that emphasizes the importance of prompt surgical repair for the management of penile fractures. Fractures that were repaired had no organic impotence and had straight, painless erections. Those who were managed conservatively developed penile nodules and plaques, and/or penile curvature and erectile dysfunction. Penile fracture is the result of axial forces to the erect penis that result in a tear in the tunica and/or Buck's fascia of the penis. The tear in the fascia is typically transverse, involves the mid to proximal penis and is on ventral to lateral aspect. The tear can be close to or travel under the urethra, and in rare instances can extend into the corpus spongiosum or into urethra (partial or complete transactions). Patients with blood at the meatus or any degree of hematuria and penile fracture need to have the urethra evaluated for concomitant injury. This can be done preoperatively with a retrograde urethrogram or intraoperatively by flexible cystoscopy or by injecting blue-tinged saline retrograde and evaluating for extravasation. The diagnosis of

penile fracture is based on history and physical examination. In rare instances, rupture of the dorsal vein can mimic a penile fracture. Otherwise, the diagnosis is often easy to make. Cavernosography is cumbersome, invasive, rarely ever performed, and generally unnecessary to make the diagnosis. In equivocal cases, magnetic resonance imaging may have a role in the diagnosis of penile fracture, since it is a noninvasive and sensitive and specific modality.

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### **Treatment of pelvic fracture-related urethral trauma: a survey of current practice in the UK**

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*BJU Int. 2005; 96: 127-30*

**Objective:** To quantify experience of pelvic fracture-related urethral trauma (PFUT), a condition not often encountered and managed by urologists.

**Methods:** The consultant urologists of the UK and Ireland were contacted informally to establish their experience with PFUT and its management, both immediate and delayed. In addition, particular individuals thought to have a specific interest in PFUT were targeted for more data.

**Results:** The overall response rate was 49% (235 responders), representing 78% of urological departments, including all the targeted individuals. Of the responders, 129 (55%) had never seen PFUT in 1-25 years of consultant practice. Only four urologists (2% of responders) saw three or more cases a year. Another four (2%) saw one or two cases per year and the remaining 98 (41%) saw PFUT less frequently. Acutely, 69% of urologists who treated PFUT did so by placing a urethral catheter. Subsequent strictures were treated endoscopically for as long as this was possible. The other 31% inserted a suprapubic catheter and referred the patient for reconstructive surgery if needed. Those who used urethroplasty for strictures after PFUT were identified and targeted; half used urethral mobilization and spatulated anastomosis alone. Only three surgeons performed more than five procedures a year.

**Conclusion:** Whatever a specialist reconstructive unit might do, practice in the wider urological community is different. Even within specialized units, PFUT is rare and the surgical management is often significantly different from published 'expert' opinion.

### **Editorial Comment**

This British paper eloquently states what those of us who specialize in trauma and urethral reconstructive surgery have experienced in practice for years. Despite a wealth of literature supporting that managing urethral distractions by a "reconstructive ladder" is antiquated and prone to failure, this is the most common method practiced by contemporary British and Irish urologists. Furthermore, most UK urologists manage only a handful of urethral distraction injuries their entire career, and even fewer have performed a posterior urethroplasty. It is this general lack of experience and knowledge of the literature that makes minimally invasive methods of management disproportionately popular. Posterior urethral injury from pelvic fracture is a distraction injury where the space between the separated ends of the urethra fills with scar. Thus, posterior urethral distraction

injuries are not really urethral strictures, and thus minimally invasive methods and “cut to the light” procedures do not have any durable success.

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## **PATHOLOGY**

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### **Prognostic and predictive factors and reporting of prostate carcinoma in prostate needle biopsy specimens**

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*Scand J Urol Nephrol Suppl. 2005; 216: 20-33*

The information provided in the surgical pathology report of a prostate needle biopsy of carcinoma has become critical in the subsequent management and prognostication of the cancer. The surgical pathology report should thus be comprehensive and yet succinct in providing relevant information consistently to urologists, radiation oncologists and oncologists and, thereby, to the patient. This paper reflects the current recommendations of the 2004 World Health Organization-sponsored International Consultation, which was co-sponsored by the College of American Pathologists. It builds on the existing work of several organizations, including the College of American Pathologists, the Association of Directors of Anatomic and Surgical Pathologists, the Royal Society of Pathologists, the European Society of Urologic Pathology and the European Randomized Study of Screening for Prostate Cancer.

### **Editorial Comment**

This consensus meeting was held in Stockholm in 2004 and sponsored by the World Health Organization. I will emphasize some topics of interest for the urologist.

1. Histopathologic type: greater than 99% of all carcinomas are acinar. The remain types include urothelial, ductal (endometrioid), mucinous, signet ring cell, adenosquamous, small cell carcinoma and sarcomatoid carcinoma. Although uncommon, the aggregate data on these variants suggest that they may have diagnostic, prognostic or therapeutic importance. Urothelial carcinoma is not hormone dependent. Small cell carcinoma (with or without neuroendocrine differentiation) is usually associated with widespread, often concurrent, metastasis (frequently to unusual locations) and rapid acceleration of clinical course. Sarcomatoid carcinoma (carcinosarcoma) of the prostate, like small cell carcinoma, has an extremely poor prognosis with a median survival of 3 years.

2. Gleason score: it predicts findings in radical prostatectomy (pathologic stage), biochemical progression, local recurrences, and lymph node or distant metastasis. The most significant recommendation is to separately report the Gleason score for each recognizable core irrespective of whether the cores are individually submitted (in individual container signifying specific anatomic location), or submitted together. Another important change is the recognition and reporting of the tertiary pattern of higher grade in needle biopsies. A case with primary pattern 3, secondary pattern 4, and tertiary pattern 5 should be assigned a Gleason score  $3 + 5 = 8$ .