Management of patient expectations in correcting penile curvature is paramount. As in other plication-based therapies, penile length already lost to underlying disease cannot be reclaimed. Additionally, indentations or hourglass deformities cannot be corrected with this technique. There are, however, some very compelling advantages to this procedure. It may be performed under a local anesthetic, there is essentially no risk of de novo erectile dysfunction, and it can often be performed using a longitudinal incision, which is particularly helpful in an uncircumcised patient wishing to retain his prepuce. Before surgery, it is important to try to get an objective view of the penile deformity, conducted by patient self-photography or with a pharmacologic injection in clinic, although both methods have disadvantages. When the patient is brought to the operating room, he is injected with 60-mg papavarine to induce erection. Pharmacologic erection is preferable to saline infusion, because the compression on the corpora cavernosa necessary for saline infusion often masks the full proximal extent of the curvature.
Surgical Techniques

FIGURE 2
The figures illustrate ventral longitudinal incision for dorsal curvature. In cases of ventral curvature, a circumcision incision is used to expose the dorsal neurovascular bundle. A hemostat clamp is used to create the space (dot) between the deep dorsal vein and the paired dorsal arteries for the placement of sutures.
Once the tunica is cleaned, the center of the curve and the dots are marked. One advantage of this technique is that the dots are easily repositioned, allowing fine adjustments to be made. Each set of four dots consists of an “in-out, in-out” suture placement. Travel of the suture under the tunica should be approximately 1 cm; travel outside the tunica may be much longer. For more acute or longer curves, a longer travel is preferable, providing a longer lever-arm (less tension) as the suture is tied down. The sutures are placed, and the first throw of a “surgeon’s knot” is made. Sutures should be soft, braided, permanent material such as 2-0 Ticron (Davis and Geck, Wayne, NJ, USA) or Tevlex (Deknatel, Inc, Fall River, MA, USA). Enough tension is placed to straighten the curvature, and a clamp with a “shod” is placed at the half-knot to hold it in position. This allows fine adjustments to be made once all sutures are satisfactorily in place. After placement of all shodded-clamps, the erect penis is inspected from all angles for alignment, with adjustments made to tension of sutures as needed. A smooth clamp is placed under each half-knot to prevent overtightening, and the remaining four knots are thrown.

FIGURE 3

Adjustment of tension of right upper suture to alleviate over-correction of curvature

Rubber shod holding down the first throw of the left upper suture at the level of the tunica

Non-absorbable sutures are placed, starting outside-in and then inside-out of the tunica and secured with rubber shods
Once the penis is straight and all knots are tied, a 21-gauge scalp-vein needle is introduced into one of the corpora to evacuate blood; phenylephrine is injected, in 500-mg aliquots, to prevent development of priapism. The hole from the scalp needle is closed using a 5-0 Maxon or equivalent, then the wound is irrigated and closed in two layers: the first with 5-0 Maxon and the skin with 5-0 Dexon or equivalent. To prevent postoperative edema and ecchymoses, a petroleum-soaked gauze strip is placed over the incision, then a gauze sponge is folded into a strip and wrapped gently around the penis. A self-adhesive compression dressing is wrapped from just under the glans to the base of the penis—snug but not tight. Any penile skin not incorporated is likely to become edematous and discolored. If the patient is uncircumcised, it is crucial to retract the foreskin and include it in the compression dressing to avoid swelling or problems with paraphimosis. Ice-packs should be used liberally in the postoperative period, and the dressing changed by a physician the next day and daily by the patient for 4 more days. Sexual intercourse can be resumed 5–6 weeks after surgery.

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