

Sexual Functional Prognosis of Penile Emergencies at the University Hospital of Libreville

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Abstract

Introduction: Penile emergencies are multiple and varied, and they can jeopardize the sexual functional prognosis of the patient. The objective of our study was to evaluate the sexual functional prognosis of patients admitted for penile emergencies. **Patients and Methods:** We conducted a cross-sectional study from January 1 to 31, 2021, in the urology department of the University Hospital. Variables included sociodemographic, diagnostic, and evolutionary data of sexually active patients admitted for a penile emergency. **Results:** During this period, 68 patients were admitted for penile emergencies. We included 45 sexually active patients, with a mean age ranging from 34.5 ± 14.1 years with extremes of 16 and 90 years. The most frequent penile emergencies were priapism (62.2%) and penile fracture (22.2%), with a mean time for treatment of 21.4 ± 52.5 hours. The sexual functional prognosis was very satisfactory (normal erection) in 71.1% ($n = 32$) of patients. Loss of erectile function was observed in 4.4% ($n = 2$) of cases. **Conclusion:** Penile emergencies are relatively frequent, dominated by priapism and penile fracture in our context. The sexual functional prognosis is good.

Keywords

Penile Emergency, Diagnosis, Sexual Functional Prognosis, Libreville

1. Introduction

Penile emergencies are a group of pathologies, traumatic or not, which affect the penis and require immediate and early treatment within the first 6 hours [1].

They are due to pathologies caused by various anomalies of the erectile hemodynamics, among the most frequent we can mention, priapism, penis fracture, and penis self-mutilation [1]. These are uroandrological emergencies. Their etiologies are multiple and varied, ranging from coitus failure in the case of penile fracture to sickle cell disease in the case of priapism [2].

Their occurrence is exceptionally life-threatening, but the functional prognosis can be disastrous, even leading to the loss of erection, and can be responsible for social drama.

In Western countries, penile emergencies occur mainly during sexual intercourse [3] [4] [5] [6]. In Africa, data on penile emergencies are not widely available, and they are probably underestimated in terms of frequency, but traumatic penile emergencies and priapism are the most frequently reported [1] [7] [8] [9].

Some data exist for some of these penile emergencies but not their possible impact on sexuality. The purpose of our study is to report the functional prognosis of patients treated for all penile emergencies at the University Hospital.

2. Patients and Methods

This was a cross-sectional, descriptive, single-center analytical study conducted from January 1 to 31, 2021, in the urology department of the UHC of Libreville. We interviewed patients treated for penile emergencies since the reopening of the urology service in 2016 about the quality of their sexual health. Patients aged 15 years or older hospitalized for penile emergencies were included regardless of the treatment administered. Patients younger than 15 years at the study time were omitted. Exclusion criteria were lack of sexual activity during the previous 6 months and refusal to sign the informed consent document.

The variables studied were sociodemographic (age, occupation, marital status, and residence). Age was grouped into 4 15-year age groups: [15 - 29], [30 - 44], [45 - 64], ≥ 65 years. Diagnostic parameters studied were history, time to urology consultation, and retained diagnosis. Therapeutic parameters included time to and type of treatment.

We studied the immediate outcome, the post-treatment evolution, and the IIEF5 score in evolution and prognosis. Urology consultation time was between the onset of symptoms and the consultation with a urologist at UHC. Time to urology treatment was the time from hospitalization to medical or surgical treatment of the patient. We defined peripheral treatment as any drug or non-drug means administered to the patient outside the urology department. We then looked for an association between these parameters and the quality of sexual function.

For the evaluation of erectile function, each patient was asked to complete a telephone survey based on the contact information provided in the records. The International Index of Erectile Function score (IIEF5) was used to evaluate erectile quality objectively. This score is a simplified version of the IIEF₅. It is a self-administered survey with 15 items in 5 different domains, including erectile function, sexual satisfaction, orgasmic function, sexual desire, and overall satis-

faction. Answers are rated from 0 to 5 per question. It allows the detection and objectification of the level of erectile dysfunction. Its rating is as follows:

- 6 - 10: severe erectile dysfunction;
- 11 - 16: moderate erectile dysfunction;
- 17 - 21: mild to moderate erectile dysfunction;
- 22 - 25: mild erectile dysfunction;
- 26 - 30: no erectile dysfunction.

Data were collected using a standardized collection form. Data entry and analysis were performed using EPI info version 7.2.4.0 and Excel version 2013. We looked for an association between the type of penile emergency, the consultation time, the treatment time, and the sexual functional prognosis of the patients. The proportions were compared using the Pearson chi-squared test with a significance level of 5%.

On ethical and regulatory aspects, only patients who had signed an informed consent document (that of the legal representative if the patient was under 18 years of age) were included in the study, and we also obtained authorization from the general treatment of the UHC and the urology department to conduct this study. However, the data collection forms were kept secure within the department, and only team members who had signed a confidentiality agreement had access to the data.

3. Results

We recorded 68 patients admitted for penile emergencies (PE) out of 1938 hospitalized in the urology department during the study period. We included 45 of them, and the prevalence of penile emergencies was 3.5%. About your comment about patient volume in one month, it was more of a cross-sectional analysis during one month of patients previously managed over a 5 year period from 2016 to 2020 in our department.

The mean age of the patients was 34.5 ± 14.1 years, with extremes of 16 and 90 years. Grouping by age showed a peak in frequency in the [15 - 29] age group with 44.4% of patients ($n = 20$). 18 patients (40%) were between 30 and 44 years of age; 5 (11.1%) were between 45 and 64 years of age, and only 2 patients (4.4%) were at least 65 years of age.

Sickle cell disease and priapism were the most common antecedents with 28.9% ($n = 13$) and 22.2% ($n = 10$) of cases. 7 were homozygous sickle cell (SS) and 03 heterozygous (AS) regarding sickle cell patients.

Our sample's most represented penile emergency was priapism with 62.2%, followed by a penile fracture with 22.2% of cases.

All these diagnostic aspects are presented below in **Table 1**.

Painful erection was the reason for consultation in 66.7% of cases ($n = 30$), followed by post-traumatic swelling of the penis with 28.9% of cases ($n = 13$). Penile bites represented 4.4% of cases ($n = 2$). The average delay for consultation in urology was 1.3 ± 2.3 days with extremes of 30 min and 3 months. 16 patients

Table 1. Distribution of patients treated for penile emergencies from 2016 to 2020 at UHC.

History	Number	(%)
Priapism	13	28.9
Sickle cell disease	10	22.2
EGO trauma	2	4.4
Diabetes	4	8.9
Aphrodisiac use	2	4.4
Psychiatric disorder	2	4.4
Taking anti-inflammatory medications	1	2.2
Stenosis of the urethra	1	2.2
None	10	22.2
Diagnosis		
Non-traumatic penile emergencies	29	64.4
Priapism	28	62.2
Penile thrombosis	1	2.2
Traumatic penile emergencies	16	34.4
Penile fracture	10	22.2
Penile wound	2	4.4
Ischemic gangrene of the glans	1	2.2
Penile phlegmon	1	2.2
Intra urethral foreign body	1	2.2
Partial amputation of the penis	1	2.2

*EGO = External Genital Organs.

(35.6% of the cases) had consulted between 0 and 6 hours, 6 patients (13.3%) between 6 and 12 hours, 5 (11.1%) between 12 and 24 hours, and 11 cases (24.4%) after 24 hours. This delay was not specified in 7 patients (15.6%).

The mean age of patients treated specifically for priapism was 35.2 ± 17 years. A history of priapism was found in 13 (46.4%) patients followed by sickle cell disease in 09 (32.1%) patients. Twenty-three (23) patients (82.1%) had a normal erection, 3 (10.7) patients had a mild erectile dysfunction and one (3.6%) patient had a total loss of erectile function. The age, history, reason for consultation and results of the treatment are listed in **Table 2**.

In our series, penile fracture accounted for 22.2% (n = 10) of patients treated for penile emergencies. The mean age of these patients was 34.7 ± 5.5 years with extremes of 29 and 42 years. The age range [30 - 44 years] represented 8 patients or 80% of cases (**Table 3**). All patients had undergone surgical management, which consisted of albuginorrhaphy in 9 cases (90%). A cavernoplasty was performed in

Table 2. Summary of patients managed for priapism at UHC from 2016 to 2020.

Settings	Number (n)	(%)
Age (ans)		
15 - 29	15	53.6
30 - 44	6	21.4
45 - 64	5	17.9
65 et +	2	7.1
History		
Trauma of the bursa	1	3.6
Priapism	13	46.4
Sickle cell disease	9	32.1
Aphrodisiac	2	7.2
Diabetes	3	60.7
Time of consultation		
0 - 6	8	28.6
6 - 12	3	10.7
12 - 24	4	14.3
>24	9	32.1
Unknown	12	42.9
Time of treatment		
0 - 6	11	39.3
6 - 12	0	0
12 - 24	1	3.6
>24	4	14.3
Unknown	12	42.9
Treatment		
Medical and instrumental	20	71.4
Médical and surgical	8	28.6
Résultats after treatment		
Detumescence	28	100

one patient who consulted 3 months after the trauma. Erection inhibition with cyproterone acetate was systematically associated for one month.

The average time for care in urology was 2 hours, and it varied from immediate care to 10 days. Twenty (20) patients or 44.4% of cases were treated between 0 and 6 hours. This time was not specified in 37.8% of cases (Table 4).

Peripheral care ranged from no treatment in 60% of patients (n = 27) to analgesic administration in 22.2% (n = 10) of cases. Puncture of the corpora cavernosa

Table 3. Summary of patients managed for penile fracture at UHC from 2016 to 2020.

Parameters	Number (n)	(%)
Age (ans)		
15 - 29	2	20,0
30 - 44	8	80,0
45 - 64	0	0,0
65 et +	0	0,0
History		
Sickle cell disease AS	1	10,0
Nothing	9	90,0
Reason for consultation		
Post traumatic swelling of the penis	9	90,0
Painful erection	1	10,0
Treatment		
Surgical	1	10,0
Medical and surgical	9	90,0
Results		
Détuméfaction	9	90,0
Not precised	1	10,0
Time of consultation (H)		
0 - 6	4	40
6 - 12	2	20
12 - 24	1	10
>24	2	20
Unknown	1	10
Time of treatment (H)		
0 - 6	5	50
6 - 12	2	20
12 - 24	0	0
>24	0	0
Unknown	3	30

was performed in 3 patients (6.7%), and the use of small means (sexual intercourse and cold) was reported in 8.8% (n = 4) of patients.

Puncture of the corpora cavernosa was performed in 19 patients, *i.e.*, 42.2% of cases. It was associated with intracavernous injection of diluted adrenaline in 4 patients. All patients had received medical treatment to inhibit postoperative

erections (20% of cases) or hyperhydration in sickle cell patients (20% of cases). One patient treated for penile thrombosis was put on an anticoagulant. Surgically, albuginorrhaphy and cavernous-spongy shunt were performed in 9 (20.0%) and 8 (17.8%) of the patients, respectively.

The sexual functional prognosis was satisfactory in 80% of the patients with an IIEF₅ score of 26 to 30. 4 patients (8.8%) had lost their erectile function (Figure 1).

There was no association between type of penile emergency and sexual functional prognosis ($p = 0.102$). Patients hospitalized for penile fracture and priapism had regained normal erectile function in 90% and 82.1% of cases, respectively. 4 patients treated for ischemic gangrene of the penis, total amputation of the penis, priapism, and intraurethral foreign body had a complete loss of erectile function. The comparison between the type of penile emergency and the functional prognosis is summarized in Table 4.

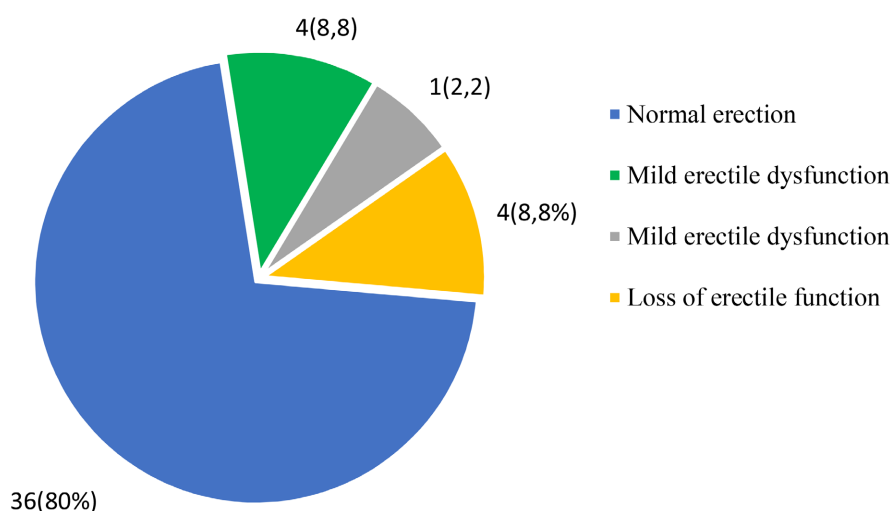


Figure 1. Distribution of patients treated for penile emergencies from 2016 to 2020 at UHC according to sexual functional prognosis.

Table 4. Sexual functional prognosis and type of penile emergency of patients at UHC.

Penile Emergencies	Normal Erection n (%)	Mild Disorder n (%)	Moderate Disorder n (%)	Loss of EF n (%)	Total	P
Priapism	23 (82.1)	3 (10.7)	1 (3.6)	1 (3.6)	28 (100.0)	0.482
Penile fracture	9 (90.0)	1 (10.0)	0 (0.0)	0 (0.0)	10 (100.0)	0.848
Penile wound	2 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)	1.000
Partial amputation of the penis	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	1 (100.0)	1.000
Intra urethral foreign body	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	1 (100.0)	1.000
Ischemic gangrene of the penis	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	1 (100.0)	1.000
Penile phlegmon	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	1.000
Penile thrombosis	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	1.000

There was no association between the functional prognosis and the time of consultation ($p = 0.319$). Between 0 and 6 hours, 15 patients or 93.8% of the cases had recovered a normal erection. Among those who consulted after 24 hours, 7 patients (63.6%) also regained a normal erection (**Table 5**).

Comparison of the time to treatment and sexual functional prognosis showed no association ($p = 0.932$). Of the 20 patients treated between 0 and 6 hours, 2 (10%) had lost their erectile function, and of those treated beyond 24 hours, 75% had maintained a normal erection (**Table 6**).

4. Discussion

The mean age of the patients in this study was 34.5 ± 14.1 years, and this means that the patients were young, with the 15 - 29 age group accounting for almost half of the total number. This result is similar to that of Kouame *et al.* [1], in whom the 15 - 25 age group is the most affected, with 36.5% of cases. This average age is higher than that reported by Diabaté *et al.* [7], 21.9 ± 18.5 years in their series on amputations and other penile trauma in Senegal. On the other hand, our patients are relatively younger than Niang *et al.* [9] in Senegal and those of Barry *et al.* [10] in Guinea Conakry, who report an average of 36 and 37 years in comparison to their series on penis fracture. Despite some differences in the authors mentioned above, most cases were in young adults, and this could be explained by the fact that this is the age of intense sexual activity, often using aphrodisiacs.

Priapism and penis fracture were the most common diagnoses in our study, with 62.2% and 22.2% of patients, respectively. This result was identical to that found in Côte d'Ivoire in Kouamé *et al.* [1]. In Diabaté *et al.* [7], penile fracture

Table 5. Sexual functional prognosis and consultation time for penile emergencies at UHC.

Time to consultation (H)	Normal erection	Mild Disorder	Moderate Disorder	Loss of EF	Total	P
0 - 6	15 (93.8)	0 (0.0)	0 (0.0)	1 (6.3)	16 (100.0)	0.212
6 - 12	4 (66.7)	1 (16.7)	0 (0.0)	1 (16.7)	6 (100.0)	1.000
12 - 24	4 (80.0)	1 (20.0)	0 (0.0)	0 (0.0)	5 (100.0)	1.000
+24	7 (63.6)	2 (18.2)	1 (9.1)	1 (9.1)	11 (100.0)	0.243

Table 6. Sexual functional prognosis and time to treat penile emergencies at UHC.

Time to treatment (H)	Normal erection	Mild Disorder	Moderate Disorder	Loss of EF	Total	P
0 - 6	15 (75.0)	2 (10.0)	1 (5.0)	2 (10.0)	20 (100.0)	0.711
6 - 12	2 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (100.0)	1.000
12 - 24	1 (50.0)	1 (50.0)	0 (0.0)	0 (0.0)	2 (100.0)	1.000
+24	3 (75.0)	1 (25.0)	0 (0.0)	0 (0.0)	4 (100.0)	1.000

represented only 13.3% of the patients, while penile wounds and amputations were more frequent with 73.3% of the cases.

The comparison between the different types of penile emergencies and the sexual functional prognosis of our patients did not find a significant difference ($p = 0.102$). Patients treated for penile fracture had a better prognosis (90% of cases of normal erection) than those treated for priapism (82.1% of cases of normal erection). Also, despite the rarity of the cases, intraurethral foreign body, amputation, and ischemic gangrene of the penis had a poor prognosis; Ischemic gangrene in the series by Moutawakkil *et al.* [11] also had a poor prognosis.

We did not find any association between the consultation time and the sexual function prognosis ($p = 0.319$). Of the patients seen between 0 and 6 hours, 93.8% of the cases had recovered a normal erection. Among those seen after 24 hours, only 63.6% had recovered a normal erection. Despite the absence of an obvious association, patients seen earlier had a better prognosis. This lack of association may be due to the small size of our sample.

Moreover, Kouamé *et al.* [1] state that their failure rate of 28.9% among patients treated for priapism was related to the delay in consultation. Slimen *et al.* [2] reported that 38.1% of patients with significant erectile dysfunction despite a preserved libido had the most prolonged delay in consultation, ranging from 3 to 10 days (average 6.6 days). For Falandry *et al.* [12], whatever the etiology, the severity of the sequelae depends essentially on the time factor, even if this is not the only parameter. Although some priapism, especially in sickle cell disease, may persist for a few days without leaving any sequelae due to chronic hypoxia or incomplete blockage of cavernous drainage, all the authors agree that the sequelae are more severe than those of the other patients. All authors agree on the harmfulness of the time elapsed because it allows the installation of a vicious circle aggravating anoxia and histological suffering, which progressively gives way to tissue necrosis responsible after the 48th hour, for a significant sequelae fibrosis and a risk of definitive impotence of about 60%. The rate of impotence is greater than 80% after the fourth day.

The difference between treatment time and the sexual functional prognosis was also insignificant ($p = 0.932$). Among the 20 patients treated between 0 and 6 hours, 2 (10%) had lost their erectile function, and among those treated beyond 24 hours, 75% had maintained a normal erection. This lack of association must be qualified by the type of penile emergency treated during these different time slots because several authors incriminate the length of this delay. Slimen *et al.* [2] find that the time taken to attend seems to be the most important factor. The longer the delay, the higher the risk of permanent sexual dysfunction, since 66.7% of their patients treated within the first 72 hours recovered a normal erection, whereas only 25% of patients treated after this delay had a favorable evolution. Bouya *et al.* [8] report that all ten patients with absent or insufficient erection were treated after the 30th hour and that among the five patients treated with intracavernous injection of etilefrine, all three successes were observed in patients seen before the 24th hour. Kamel *et al.* [13] consider that the

risk of secondary erectile dysfunction depends on several factors: the delay in treatment. In their series, only two had a favorable outcome among the ten patients treated beyond the third day (28% of cases). For the 12 patients treated between the 12th and 72nd hour, 6 (50%) maintained regular sexual activity, while the others became impotent. For Ouattara *et al.* [14], adequate diagnosis and prompt treatment of the penile fracture are necessary to prevent the development of organic and functional complications. However, all these studies have small numbers. Therefore, it is not easy to substantiate their claims because the statistical tests we performed may not confirm them.

The sexual functional prognosis was satisfactory in 80% of the patients in this study. 4 patients (8.8%), including one admitted for priapism, had completely lost their erection. Only one patient had a mild erectile dysfunction after a penile fracture. These results are similar to Kouamé *et al.* [1], with 80% of patients maintaining a normal erection and good sexual function. Bouya *et al.* [8] in Congo Brazzaville, Habou *et al.* [15] in Niger, and Kassogué *et al.* [11] in Mali found a lower result with respectively 50%, 58.3%, and 31% of patients having a normal erectile function. Falandry *et al.* [12] report more alarming results with 56.8% of a total loss of erectile function. Our rather satisfactory results could be attributed to the age of our patients, the short consultation time, and the rapidity of the treatment.

The limitations of the study are first of all related to the small sample size that does not allow for definite correlations. It was also difficult for diabetic patients to differentiate between erectile dysfunction related to the occurrence of penile urgency and their comorbidity.

5. Conclusion

Penile emergencies are manifold but dominated by penile fracture and priapism. They occur in young adults with a history of priapism and sickle cell disease. The diagnosis of these emergencies is clinical. The type of penile emergency, consultation, and treatment delays are not associated with the sexual functional prognosis, which is globally satisfactory in our context.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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Question 1

Questionnaire for the study of the sexual functional prognosis of penile emergencies managed at the urology department of the University Hospital of Libreville from January 1, 2016 to December 31, 2020.

Identity of the patient

Date of collection:

Date of birth: _____ Age: _____

File number: _____

Phone number: _____

Occupation: _____

Marital status: married cohabiting single

History/conditions prior to the penile emergency:

Sickle cell disease: yes no

Circumcision: Location practicing

Traumatisme:

Previous episode of spontaneously resolving painful erection:

Previous episode of priapism: yes no

Other:

Clinic at time of penile emergency

Peripheral management: _____

Time to urology consultation: _____

Reason for consultation: _____

 Painful erection without sexual stimulation

 Painful erection after sexual stimulation

 Swelling of the penis Penile trauma Other

Diagnosis: _____

 Priapism Fracture of the penis Mutilation of the penis

 Other

Treatment received

Time and nature of management of penile emergency in periphery: _____

Time to consultation of penile emergency in urology: _____

Time to management of penile emergency in urology: _____

Nature of management in urology: _____

 Medical Puncture/Wash Surgery

Immediate outcome: _____

Course/Follow-up: _____

Date of last sexual intercourse: _____

IIFE5 Score Result: _____