Surgical Science, 2025, 16(8), 379-388
https://www.scirp.org/journal/ss
ISSN Online: 2157-9415
ISSN Print: 2157-9407

Management of Penile Fractures in Bujumbura: Epidemiological, Diagnostic, Therapeutic and Functional Outcome Aspects

Steve Nkurunziza[1*], Linda Elodie Njebarikanuye[2], Ben Saad Hamda[3], Bahria Ayoub[3], Ali Chakroun[3], Gallina Kazobinka[4], Jean Luc Bagaya[1], Stanislas Harakandi[5], Jean Claude Mbonicura[6], Réverien Ndayirorere[1], Paul Banderembako[1]

[1]Department of Uro-Andrology, Universitary Center for Health Research, Faculty of Medicine, University of Burundi, Bujumbura, Burundi
[2]Department of Medical Imaging, Universitary Center for Health Research, Faculty of Medicine, University of Burundi, Bujumbura, Burundi
[3]Department of Urology, Tahar Sfar Hospital, Mahdia, Tunisia
[4]Department of Uro-Andrology, KIRA Hospital, Bujumbura, Burundi
[5]Department of Anesthesia-Resuscitation, Universitary Center for Health Research, Faculty of Medicine, University of Burundi, Bujumbura, Burundi
[6]Department of General and Gastro-Intestinal Surgery, Universitary Center for Health Research, Faculty of Medicine, University of Burundi, Bujumbura, Burundi
Email: *stevenineza@gmail.com

How to cite this paper: Nkurunziza, S., Njebarikanuye, L.E., Hamda, B.S., Ayoub, B., Chakroun, A., Kazobinka, G., Bagaya, J.L., Harakandi, S., Mbonicura, J.C., Ndayirorere, R. and Banderembako, P. (2025) Management of Penile Fractures in Bujumbura: Epidemiological, Diagnostic, Therapeutic and Functional Outcome Aspects. *Surgical Science*, **16**, 379-388.
https://doi.org/10.4236/ss.2025.168038

Received: December 1, 2024
Accepted: August 18, 2025
Published: August 21, 2025

Abstract

Background: Penile fracture is a rare non-infectious emergency of the lower urinary tract and genital organs. **Aim:** To analyze the epidemiological, diagnostic, therapeutic, and outcomes aspects of penile fracture in the uro-andrology departments of the Kamenge University Hospital Center and KIRA Hospital at Bujumbura. **Patients and Methods:** This prospective descriptive study analyzed four cases of penile fracture managed at Kamenge University Hospital and KIRA Hospital (Burundi) over a one-year period (April 1, 2022, to March 31, 2023). **Results:** During the period of our study, 4 patients were operated for penile fracture. The average age was 33.4 years. Penile fractures accounted for 2.16% of uro-andrological emergencies (n = 4). Three patients (75%) were married while the other (25%) was single. Sexual intercourse with coital misstep was the leading cause (75%). All patients presented with pain, swelling, and a cracking sound; urethrorrhagia was noted in one case. Surgical exploration confirmed tunica albuginea rupture in all cases, with one patient having an associated urethral injury. All patients underwent surgical repair. Three patients (75%) had undergone albuginorraphy and a cavernorraphy associated with albuginorraphy was performed in one patient (25%). A Foley catheter

was inserted. At 3-month follow-up, three patients had normal erectile function (IIEF-5: 22 - 25), while one had mild dysfunction (IIEF-5: 20). **Conclusion:** Penile fracture is a rare but serious urological emergency. Early diagnosis and immediate surgical management of penile fractures yield favorable outcomes with low complication rates. A high index of suspicion and prompt intervention are key to preserving sexual function and avoiding long-term sequelae.

Keywords

Penile Fracture, Uro-Andrological Emergency, Albuginorraphy, Cavernorraphy

1. Introduction

Penile fracture is a rare non-infectious emergency of the lower urinary tract and genital organs [1]. It is a rare uro-andrological injury that is defined as rupture of the tunica albuginea of the corpora cavernosa as a result of blunt or bending trauma to the erect penis [2]. Penile fracture is a well-codified urological emergency that demands urgent care, and both the European Association of Urology (EAU) and the American Urological Association (AUA) recommend exploration and surgical repair for any suspected case [3] [4]. The most common causes are blunt trauma during sexual intercourse, bed-rolling, masturbation, unconscious nocturnal manipulation of the penis, or a fall onto an erect penis [5]. Other causes, such as self-inflicted trauma to achieve rapid detumescence of the penis (known as the practice of "Taqnaadan" in the Middle East and North Africa), blunt trauma to the flaccid penis, or more recently, injections of Clostridium histolyticum collagenase for Lapeyronie's disease, have also been reported [6]-[10]. The rupture may extend to the corpus spongiosum and urethra [11]. The diagnosis of a penile fracture is usually made on the basis of the patient's history and physical examination. However, in some cases, ultrasound, MRI or cavernosography are essential to the diagnosis [1]. Penile fracture requires surgical exploration and repair, as conservative treatment is associated with complications such as erectile dysfunction, fibrosis, painful erection, curvature, hematoma infection, and false aneurysm, with an incidence of up to 30% [7]. Literature shows that immediate surgical repair leads to better outcomes, while conservative management is associated with complications such as penile curvature (30%) and erectile dysfunction (50% to 62%) [12] [13]. Recommendations for surgical approach and repair techniques vary, with three main approaches: penile degloving via incision under the balanopreputial groove, the elective approach, and the penoscrotal approach [14]. Most reviews now recommend immediate surgical exploration and primary closure of the tunica albuginea. Data on the effects of penile fracture surgery on urinary and sexual function outcomes come from retrospective studies on small and therefore underpowered patient populations [15]. This study aims to analyze the epidemiological, diagnostic, therapeutic, and outcome aspects of penile fracture and compare them with data from the literature.

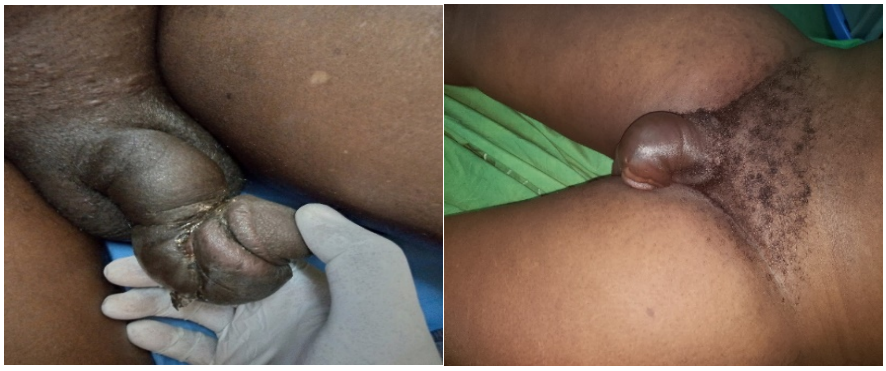
2. Patients and Methods

This was a prospective descriptive study of patients treated for penile fracture in the uro-andrology departments of the Kamenge University Hospital and KIRA Hospital over a one-year period (April 1, 2022, to March 31, 2023). Initial assessment was based on physical examination and medical history. Variables analyzed included age, marital status, time to consultation, reason for consultation, etiology, symptoms, diagnostic tests, treatment, complications, and erectile function during follow-up. Additional data included time from trauma to presentation, size and location of hematomas, penile deviation, urethral bleeding, and location and size of ruptures. Ultrasound was used for diagnosis confirmation and lesion measurement. Patients received broad-spectrum antibiotics, hematomas were evacuated, and tunica albuginea was repaired using absorbable sutures. A Foley catheter was placed intraoperatively, and all patients received soft compression dressings postoperatively.

Patients were followed for up to 3 months, with clinical data and the International Index of Erectile Function (IIEF-5) score recorded. Data were entered using SPSS version 26, and processed in Microsoft Word 2016 and Excel 2016.

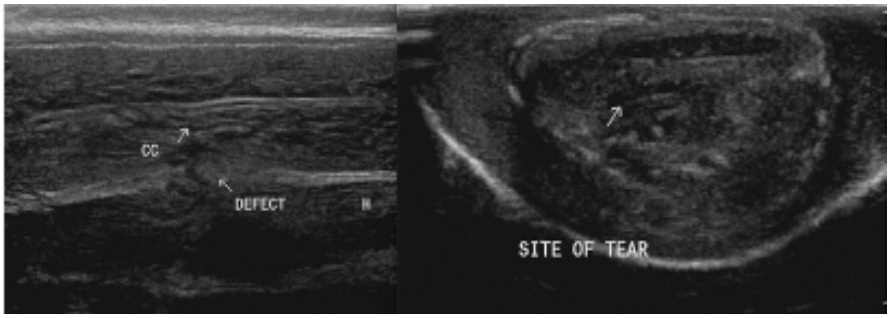
3. Results

During the study period, 185 patients were admitted for uro-andrological emergencies. Penile fractures accounted for 2.16% (n = 4) of these cases. The average age of our patients was 33.4 years. Three patients (75%) were married. Sexual intercourse with a coital misstep was the most common cause (75%), followed by bed-rolling (25%). Pain, swelling, and a cracking sound were reported by all patients. One patient had urethrorrhagia. A large hematoma causing penile deviation was observed in 3 patients (**Figure 1**). Ultrasound of the penis confirmed penile fracture in all patients (**Figure 2**). No patient underwent MRI. All patients underwent surgery under spinal anesthesia. Three patients (75%) underwent albuginorrhaphy, and one patient (25%) had cavernorraphy performed three months after trauma. One patient had complex bilateral corpora cavernosa fractures with urethral rupture; the others had unilateral fractures. Most ruptures (75%) were located in the middle third of the penis. Hematomas were observed in all patients. Treatment included hematoma evacuation and suturing of the tunica albuginea via circumferential incision under the coronal sulcu (**Figure 3(a)**). The approach was a circumferential incision under the coronal bone, with the penis removed down to the site of the fracture. The urethral rupture was repaired with Foley catheter placement. Skin was closed with simple stitches (**Figure 3(b)**). No intraoperative complications occurred. The average treatment delay was 2.4 hours. Most patients were discharged the next day. The urinary catheter was removed on postoperative day 14 in the patient with urethral repair. At 3-month follow-up, one patient (25%) had mild erectile dysfunction (IIEF-5 score: 20), while the others (75%) had normal function (IIEF-5 scores: 22 - 25). The characteristics of our patients are summarized in **Table 1**.



(a) (b)

Figure 1. Post-traumatic deviation of the penis.



(a) (b)

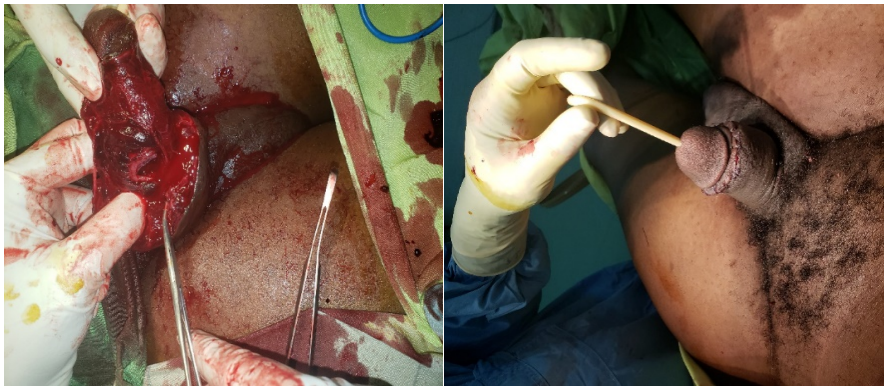
Figure 2. Ultrasound image showing a rupture of the tunica albuginea of the corpora cavernosa, confirming a penile fracture.

Table 1. The following table shows the characteristics of our patients

Parameters		Workforce	Percentage (%)
Age bracket	15 - 29	1	25
	30 - 44	2	50
	44 - 65	1	25
Reason for consultation	Post-traumatic swelling of the penis	3	75
	Painful erection	1	25
	Perception of a cracking sound	4	100
Causes	Sexual relations	3	75
	Unconscious nocturnal manipulation of the penis	1	25
Consultation time (Hours)	0 - 24	3	75
	>24	1	25
Physical examination signs	Pain	4	100
	Penile swelling	4	100
	Urethrorrhagia	1	25
	Haematoma	3	75
	Deviation of the penis	3	75

Continued

Treatment time after consultation (Hours)	0 - 24	**3**	**75**
	>24	1	25
Surgical management	Albuginorrhaphy	3	75
	Cavernorraphy	1	25
International Index of Erectile Function (IIEF-5) score	22 - 25	3	75
	17 - 21	1	25



(a) (b)

Figure 3. Intraoperative view of a fractured penis after surgery.

4. Discussion

Penile fracture is an uncommon urological emergency [16]. We reported 4 cases in one year. Other studies have reported: 55 cases in 10 years (Matthew Y *et al.*) [17], 13 cases in 7 years (Diallo *et al.*) [18], and 10 cases in 5 years (Mougougou *et al.*) [19]. The mean age of patients with penile fractures in our study was 33.4 years. Diallo *et al.* [7] in Senegal and Mougougou *et al.* [8] in Gabon report a similar mean age (32 and 34.7 years respectively) [18] [19]. Sarr *et al.* in Senegal, Paré *et al.* in Burkina Faso and Kpatcha *et al.* in Togo found older patients with an average age of 41.8 years, 38.3 years and 37.3 years respectively [20]-[22]. The most common reason for consultation was post-traumatic swelling (75%). Paré *et al* found it in 83.3% of patients, Mougougou *et al.* in Gabon in 90% of patients, the others having consulted for post-coital urethrorrhagia [19] [21]. The average time to treatment was 2.4 hours. It was longer than Paré *et al.*, Kpatcha *et al.* who reported 46.3 and 74 hours respectively [21] [22]. This is worse than the 1 hour found by Diallo *et al.* and close to that of Mougougou *et al* of 3.4 hours [18] [19]. Sexual intercourse with coital misstep was the leading cause (75%). A recent meta-analysis of 58 studies from 26 different countries involving 3213 patients showed that the most common presenting etiologies of penile fracture were sexual intercourse (46%), forced flexion of the penis (21%), masturbation (18%) and rolling over onto an erect penis (8.2%) [7]. However, the typical mechanism of injury varies greatly by region and culture. The diagnosis can be confirmed by Ultra-

sound and in some MRI. Ultrasound is often utilized in the emergency room setting by virtue of its speed and availability [23]. The treatment of penile fracture can be surgical or conservative. Surgical management is recognized to be superior to conservative management. The EAU 2020 guidelines recommend that penile fracture be treated surgically with closure of the tunica albuginea [24]. The committee notes that surgical treatment results in the lowest rate of adverse outcomes in the long-term in both functional and psychological well-being of patients. AUA guidelines, published in 2014 and amended in 2017, agree that surgical repair is the appropriate intervention in patients with physical and historical signs consistent with traumatic penile fracture [25]. All patients underwent surgery and were given erectile dysfunction treatment postoperatively to prevent loosening of the sutures.

This treatment is identical to that instituted by Kpatcha *et al.* in Togo, Diallo *et al.* in Senegal, Mougougou *et al.* in Gabon and Rimtebaye *et al.* in Chad who, in addition to surgical treatment, combined erectile dysfunction treatment for one month to prevent loosening of the albuginea sutures [18] [19] [22] [26]. At present, the standard treatment for ruptured corpus cavernosum in the acute phase is surgery to evacuate the subcutaneous haematoma, suture the tear in the corpus cavernosum albuginea and repair any urethral damage. The key principles of surgical management in penile fractures are exposure, evacuation of the hematoma, identification of the fracture site, ligation of bleeding vessels, thorough wound toilet and débridement, suturing of tears in the tunica albuginea and urethral repair if needed [27]. Anti-androgens and benzodiazepines were used to limit erections during the convalescence period [22] [28]. Post-operative detumescence was observed in 3 patients in this series. Reduction in penile volume after emptying of the haematoma and suturing of the albuginea is the rule. There is no consensus regarding the duration of Foley catheterization following urethral repair, but Foley catheters are generally recommended for 1 - 3 weeks in these patients, with some authors suggesting that the duration of catheterization should vary based on the extent or severity of the urethral injury [7] [27]. After an average follow-up of three months, one patient had a mild erectile dysfunction and the other three (75%) had a normal erection.

According to the British Association of Urological Surgeons (BAUS), patients should be followed-up after 2 weeks and refrain from sexual intercourse for 6 weeks. Development of postoperative penile curvature should be managed using the same management pathway as for Peyronie's disease. Postoperative erectile dysfunction can be treated with oral pharmacotherapies, followed by intracavernosal/intraurethral prostaglandin, and finally a penile prosthesis for those with end-stage erectile dysfunction [6]. Rebai *et al.* reported 15.6% mild erectile dysfunction in their series [29]. This erectile dysfunction occurred in the patient treated one month after the trauma. It is the hallmark of an untreated or late-treated fracture of the penis, which progresses to the formation of a fibrous callus, responsible for irreducible angulation of the penis and erectile dysfunction.

The long-term effects of delayed presentations and the optimal timing of subsequent intervention have caused some debate. Kozacioglu and colleagues report no serious deformity or erectile dysfunction as a consequence of delay in surgery within a given time frame in 56 penile fractures, in terms of number of hours to presentation (mean number of hours from trauma to repair 11.3 ± 8.5 hours) [30]. Similarly, el-Assmy and colleagues noted no difference in serious long-term complications between those who were treated surgically following an early (within 24 hours) or delayed (up to 7 days) presentation [31]. While rates of post-repair erectile dysfunction have been established within the literature, it should be noted that the degree of any dysfunction is typically mild for surgically repaired cases [32]. Although erectile dysfunction rates are typically low following surgically repaired penile fracture, many patients will have sexual performance anxiety and fear of recurrence of penile fracture, which can have a negative impact on self-esteem and sexual relationships that typically lasts for 12 - 24 months following injury [15] [33]. There is no standard follow-up protocol in the literature, and poor patient compliance with follow-up is common. Patients should thus be advised about early signs of long-term complications at the time of surgical repair.

5. Conclusion

Penile fracture is a urological emergency. Diagnosis is typically clinical, with imaging reserved for atypical cases. Prompt surgical repair improves outcomes and preserves sexual function. Patients with urethral injury should undergo urethroplasty with Foley catheterization. Abstinence from intercourse is recommended for 4 - 6 weeks postoperatively. Early diagnosis and surgical treatment yield favorable results and reduce long-term complications.

Conflicts of Interest

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

References

[1] Zaman, Z.R., Kommu, S.S. and Watkin, N.A. (2005) The Management of Penile Fracture Based on Clinical and Magnetic Resonance Imaging Findings. *BJU International*, **96**, 1423-1424. https://doi.org/10.1111/j.1464-410x.2005.05982_4.x

[2] Miller, S. and McAninch, J.W. (1996) Penile Fracture and Soft Tissue Injury. In: McAninch, J.W., Ed., *Traumatic and Reconstructive Urology*, Saunders, 693.

[3] Urological Trauma. Guidelines EAU 2021. https://uroweb.org/guidelines/urological-trauma

[4] AUA (2020) Urotrauma Guideline. https://www.auanet.org/guidelines-and-quality/guidelines/urotrauma-guideline

[5] Koifman, L., Cavalcanti, A.G., Manes, C.H., R. Filho, D. and Favorito, L.A. (2003) Penile Fracture: Experience in 56 Cases. *International Brazilian of Urology*, **29**, 35-39. https://doi.org/10.1590/s1677-55382003000100007

[6] Rees, R.W., Brown, G., Dorkin, T., Lucky, M., Pearcy, R., Shabbir, M., *et al.* (2018) British Association of Urological Surgeons (BAUS) Consensus Document for the Management of Male Genital Emergencies—Penile Fracture. *BJU International*, **122**,

26-28. https://doi.org/10.1111/bju.14167

[7] Amer, T., Wilson, R., Chlosta, P., AlBuheissi, S., Qazi, H., Fraser, M., *et al.* (2016) Penile Fracture: A Meta-Analysis. *Urologia Internationalis*, **96**, 315-329. https://doi.org/10.1159/000444884

[8] Zargooshi, J. (2009) Sexual Function and Tunica Albuginea Wound Healing Following Penile Fracture: An 18-Year Follow-Up Study of 352 Patients from Kermanshah, Iran. *The Journal of Sexual Medicine*, **6**, 1141-1150. https://doi.org/10.1111/j.1743-6109.2008.01117.x

[9] Hughes, W.M., Natale, C. and Hellstrom, W.J.G. (2021) The Management of Penile Fracture: A Review of the Literature with Special Consideration for Patients Undergoing Collagenase Clostridium Histolyticum Injection Therapy. *Current Urology Reports*, **22**, Article No. 13. https://doi.org/10.1007/s11934-020-01025-7

[10] Mirzazadeh, M., Fallahkarkan, M. and Hosseini, J. (2017) Penile Fracture Epidemiology, Diagnosis and Management in Iran: A Narrative Review. *Translational Andrology and Urology*, **6**, 158-166. https://doi.org/10.21037/tau.2016.12.03

[11] Faydaci, G., Ozgul, A., Kuyumcuoglu, U., Aktoz, T. and Oder, M. (2011) Dorsal Vein Rupture after Practice of Taqaandan, Necrotising Cavernositis, Penile Reconstruction, Urethroplasty and Penile Prosthesis Implantation. *Andrologia*, **44**, 851-855. https://doi.org/10.1111/j.1439-0272.2011.01259.x

[12] Boissier, R., Long, J.A., Chiron, P. and Savoie, P.-H. (2021) Urgences non infectieuses du bas appareil urinaire et des organes génitaux. *Progrès en Urologie*, **31**, 1022-1038. https://doi.org/10.1016/j.purol.2021.08.034

[13] Yamaçake, K.G.R., Tavares, A., Padovani, G.P., Guglielmetti, G.B., Cury, J. and Srougi, M. (2013) Long-Term Treatment Outcomes between Surgical Correction and Conservative Management for Penile Fracture: Retrospective Analysis. *Korean Journal of Urology*, **54**, 472-476. https://doi.org/10.4111/kju.2013.54.7.472

[14] Kominsky, H., Beebe, S., Shah, N. and Jenkins, L.C. (2019) Surgical Reconstruction for Penile Fracture: A Systematic Review. *International Journal of Impotence Research*, **32**, 75-80. https://doi.org/10.1038/s41443-019-0212-1

[15] Bolat, M.S., Özen, M., Önem, K., Açıkgöz, A. and Asci, R. (2017) Effects of Penile Fracture and Its Surgical Treatment on Psychosocial and Sexual Function. *International Journal of Impotence Research*, **29**, 244-249. https://doi.org/10.1038/ijir.2017.31

[16] Nason, G.J., McGuire, B.B., Liddy, S., Looney, A., Lennon, G.M., Mulvin, D.W., *et al.* (2013) Sexual Function Outcomes Following Fracture of the Penis. *Canadian Urological Association Journal*, **7**, 252-257. https://doi.org/10.5489/cuaj.199

[17] Yii, M., Gan, C., Qin, K.R., Bolton, D. and Blecher, G. (2024) A 10-Year Multicentre Experience of Australian Penile Fracture Repair Outcomes. *Société Internationale d'Urologie Journal*, **5**, 10-15. https://doi.org/10.3390/siuj5010005

[18] Diallo, Y., Soumah, S.A., Kouka, S.C.N., *et al.* (2014) Fracture de verge: Résultats de la prise en charge au niveau de la région de Thiès. *Journal Africain de Chirurgie*, **3**, 80-84.

[19] Mougougou, A., Olagui, S., Ndang, N., Milama, S., Ongouta, G., *et al.* (2022) Epidémiologie, Traitement et Pronostic Fonctionnel Sexuel des Fractures de la Verge au CHU de Libreville. *Health Sciences and Disease*, **23**, 12-15.

[20] Sarr, A., Allassiangar, M., Thiam, M., *et al.* (2020) La fracture de verge en milieu hospitalier senegalais. *Jaccr Africa*, **4**, 93-98.

[21] Paré, A., Ouattara, A., Botcho, G., Kirakoya, B., Kaboré, F.A., Bako, A., *et al.* (2019)

La fracture de verge: À propos de six observations au CHU Sanou Souro de Bobo-Dioulasso, Burkina Faso. *Pan African Medical Journal*, **33**, Article 257. https://doi.org/10.11604/pamj.2019.33.257.19452

[22] Kpatcha, T.M., Tengue, K., Botcho, G., Sikpa, K.H., Léloua, E., Sewa, E.V., *et al.* (2017) Notre experience de la prise en charge de la fracture de verge au CHU de Lomé. *African Journal of Urology*, **23**, 342-346. https://doi.org/10.1016/j.afju.2017.02.004

[23] Cozzi, D., Verrone, G.B., Agostini, S., Bartolini, M., D'Amico, G., Pradella, S., *et al.* (2019) Acute Penile Trauma: Imaging Features in the Emergency Setting. *La radiologia medica*, **124**, 1270-1280. https://doi.org/10.1007/s11547-019-01065-1

[24] EAU (2020) EAU Guidelines Presented at the EAU Annual Congress.

[25] Morey, A.F., Brandes, S., Dugi, D.D., Armstrong, J.H., Breyer, B.N., Broghammer, J.A., *et al.* (2014) Urotrauma: AUA Guideline. *Journal of Urology*, **192**, 327-335. https://doi.org/10.1016/j.juro.2014.05.004

[26] Rimtebaye, K., Danki, S.F., Ndoye, M., *et al.* (2015) Fracture de la verge, aspects cliniques et prise en charge, à propos de 14 cas. *Uro-Andro*, **1**, 153-156.

[27] Al-Shaiji, T.F., Amann, J. and Brock, G.B. (2009) Fractured Penis: Diagnosis and Management. *The Journal of Sexual Medicine*, **6**, 3231-3240. https://doi.org/10.1111/j.1743-6109.2009.01593.x

[28] Diarra, A., Mahamat, M.A., Kassogué, A., *et al.* (2019) La fracture de la verge à propos de 2 cas au service d'urologie du CHU Luxembourg/Mali. *Mali medical*, **34**, 58-60.

[29] Rebai, M., Kerkeni, W., Krarti, M., Ayed, H., Bouzouita, A., Cherif, M., *et al.* (2015) Dysfonction érectile après traitement chirurgical de la fracture de la verge. *Progrès en Urologie*, **25**, 773. https://doi.org/10.1016/j.purol.2015.08.117

[30] Kozacioglu, Z., Degirmenci, T., Arslan, M., Yuksel, M.B., Gunlusoy, B. and Minareci, S. (2011) Long-Term Significance of the Number of Hours until Surgical Repair of Penile Fractures. *Urologia Internationalis*, **87**, 75-79. https://doi.org/10.1159/000325589

[31] El-Assmy, A., El-Tholoth, H.S., Mohsen, T. and Ibrahiem, E.H.I. (2011) Does Timing of Presentation of Penile Fracture Affect Outcome of Surgical Intervention? *Urology*, **77**, 1388-1391. https://doi.org/10.1016/j.urology.2010.12.070

[32] Falcone, M., Garaffa, G., Castiglione, F. and Ralph, D.J. (2018) Current Management of Penile Fracture: An Up-to-Date Systematic Review. *Sexual Medicine Reviews*, **6**, 253-260. https://doi.org/10.1016/j.sxmr.2017.07.009

[33] Barros, R., Schul, A., Ornellas, P., Koifman, L. and Favorito, L.A. (2019) Impact of Surgical Treatment of Penile Fracture on Sexual Function. *Urology*, **126**, 128-133. https://doi.org/10.1016/j.urology.2018.11.047

Appendix

Questionnaire

1. Socio-Demographic and Clinical Characteristics Data

1) Patient identity:

✓ Name and surname:

✓ Age:

✓ Province:

✓ Patient Phone number: Phone number of contact person:

✓ Marital Status: Single ☐ Married ☐ Divorced ☐ Widower ☐

2) Date of admission:

3) Date of first symptoms:

4) Length of hospitalization:

5) Health care: CHUK ☐ KIRA Hospital ☐

2. Clinical Examination

1) Anamnesis

✓ Reason for consultation: Pain ☐ Penile swelling ☐ Urethral bleeding ☐

✓ Circumstance of occurrence: Sexual intercourse ☐ Masturbation ☐ bed-rolling ☐ unconscious nocturnal manipulation ☐ elf-inflicted trauma ☐ blunt trauma ☐ injections of Clostridium histolyticum collagenase ☐ Others ☐

✓ Perception of a cracking: Yes ☐ No ☐

✓ Consultation time (Hours):

2) Physical exam

✓ Penis examination: swelling ☐ Urethrorrhagia ☐ Pain ☐ hematomas ☐ Deviation ☐ Others ☐

✓ Location of the hematoma: Middle ☐ Distal ☐ Anterior ☐ Others ☐

✓ Testis: Normal ☐ Scrotal swelling ☐ Pain ☐ Others ☐

3. Additional Tests

✓ Ultrasound ☐

✓ MRI ☐

✓ Others ☐

4. Treatment

1) Conservative management ☐

2) Surgical management

o Urethral Foley catheters ☐

o Elective approach ☐

o Penoscrotal approach ☐

o Penile degloving: evacuation of the hematoma ☐ albuginorrhaphy ☐ Cavernorraphy ☐

5. Evolution

✓ International Index of Erectile Function (IIEF-5) score at 3-month follow-up: …../25