Stage II Penile Carcinoma
A case Review : Literature/Discussion

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Introduction :

Penile malignancies are not very common tumors and are often devastating for the patients and diagnostically and therapeutically challenging for the surgeon. Some penile lesions are strictly benign, whereas others have a potential to evolve into malignancies. It is seen in uncircumscribed men and is extremely rare in those who have been circumscribed. Neonatal Circumcision offers almost 100% protection, whereas circumcision later in life does not seem to be as protective. Accounting for less than 1% of malignancies, squamous cell carcinoma occurs not frequently in 50-60 yrs old age group. In situ Carcinoma of Penis is known as Erythroplasia of Queyrat if it involves the preputial sac or Bowens disease if in involves the skin of the Penis. It is a pre cancerous condition that responds to local Irradiation or 5-Fu cream.

Pathology and Staging :

Squamous cell carcinoma of penis may be seen with varying degrees of mitotic activity. It may be very well differentiated and presents as Verrucous Cancinoma. Most are well to moderately differentiated, and rarely it is undifferentiated. It arises in the pairs and spreads locally, involving the Corpora Spongiosum and then the venous system., although it initially tends to spread through the lymphatics to the superficial and deep inguinal and pelvic lymph nodes.

Jackson's Classification for CA of the Penis

Stage I (A) Tumours confined to Glans, Prepuce or both
Stage II (B) Tumours extending on to shaft or Corpora
Stage III (C) Tumours with Inguinal metastases that are operable
Stage IV (D) Tumours involving adjacent structure; inoperable inguinal metastasis or distant metastasis

Case Report :

78 yrs old elderly gentleman presented with a deep excavated ulcers with rolled in edges on the glans extending over to the shaft of penis, this was associated with foul preputial odors and purulent discharge– duration was 7 months.

The patient was apparently a symptomatic 7 months back when he noticed a small in duration over the glans, which developed into a pustule, and subsequently over a period of time developed into an ulcerative lesion.

On Examination

The patient was averagely built and nourished with vital parameter within normal range.

Local examination

Large Ulcerative lesion extending over the glans involving the prepuce, the edges rolled in. It was adherent and involved the corporeal body. The scrotum and the base of the penis was free.
Rectal examination revealed no involvement of the perineal body or pelvic mass.
Bilateral Superficial Inguinal lymph nodes were palpable.

Investigation and Results:

- Routine investigations performed were within normal limits.
- Inguinal lymph node biopsy showed reactive lymphadenits
- Incisional biopsy from the site showed moderately differentiated squamous cell carcinoma of the penis
- USG was normal
- X-ray chest-normal

Diagnosis: Carchinoma Penis (Stage II)

Plan: Total Penectomy with Perinea Urethorostomy

To inimise local recurrence as the shaft of the penis was involved, and as adequate phallic stump to allow voiding in standing position couldn't be left behind.

Surgical Procedure:

The patient was taken for Total Penectomy with perineal urethrostomy. Inguinal Lymphadenectomy not performed, as the superficial lymph nodes were negative. Post op period was uneventful and the patient was discharged with antibiotics for 4 weeks after a week stay in the hospital. Follow up after 6 weeks showed regression of lymph nodes and no complications with the urethorstomy.

The patient was followed up for a period of one year and no complication were seen till that period after which the patient failed to follow up.

Discussion :

- Carchinoma of penis usually begins with a small lesion, which extends to involve the entire glans, shaft and corpora.
- Metastases to the regional femoral and iliac nodes are the earliest route of dissemination from penile cancer.
- Clinically detectable distant sites of metastasis lesions to the lungs and bones are uncommon.
- Ca Penis is characterized by a relative progressive course causing death fort he majority of untreated patients within 2 years.
- No report of spontaneous remission of Ca Penis is known.
- Confirmation of diagnosis of Ca Penis and assessment of depth of Invasion of lesion by the HPE are mandatory before initiation of any therapy.
- No harmful effect related to tumour dissemination from biopsy of Penis has been reported.
- Gold standard for whom radiation therapy is appropriate is small.
- The number of patients for whom radiation therapy is appropriate is very small.

Treatment of Inguinal nodes:

- Prognosis of patient with Ca Penis is markedly worsened by presence of inguinal metastasis.
- Nodal metastases are associated with high-grade lesions or invasive histology.
- 20-50% patients with clinically palpable adenopathy, and histologically proven inguinal node metastasis, treated by inguinal lymphadenectomy, however achieve a 5-year disease free interval.
- Only 50% of patients presenting with palphable lymphadenopathy actually have metastasis disease, the remainder have lymphy node enlargement secondary to Inflammation.

Conclusion:

Stage II Penile Cancer is most frequently managed by Penile amputation for lacal Control. Whether the amputation is partial, total or radical will depend on the extent and location of the neoplasm. Radiation therapy with surgical salvage is an alternative approach.

YAG laser therapy has been used to preserve the penis in selected patients with small lesions.
Because of high incidence of microscopic node metastasis, elative adjunctive dissection of clinically uninvolved (negative) lymph node on conjunction with amputations is often used for patient with poorly differentiated tumour.

However, lymphadenectomy can carry substantial morbidity, such as infection, skin necrosis, wound breakdown, chronic oedema and even a low, but finite, rate.

References :

1) Lindegaard JC, Niclsen OS-BJ of Urology 77(6) 1996
2) Harty JJ, Catalona WJ: Carchinoma of Penis
3) Schell hammer PF, Spaulding JT: Ca penis
4) Johnoson DE, Lork : Tumour of Penis
5) Campbells Urology
6) Oxford Textbook of Surgery
7) Ornellas AA, Seixas AL, Marota A, et al