the procedure leads to a temporary compromise of the complex pancreatico-duodenal blood circulation, causing a temporary ischemia that manifests as local ileus. Another possibility is simply oedema of the anastomosis, but the exact cause of this "ileus" remains unclear. It has become our practice, however, to perform a feeding jejunostomy (Witzel technique) in addition to PSD to tide over this complication in the post-operative period.

REFERENCES


Penile strangulation by a hard plastic bottle: A case report

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ABSTRACT

Penile strangulation is a rare injury, but requires urgent management. Various metallic and non-metallic objects are placed over the penis to increase sexual performance or because of autoerotic intentions. We describe a case who had put a hard plastic bottle over his penis which resulted in strangulation of the penis. To remove it was a challenge as the chances of injury to the surgeon and the patient were high. Patient was successfully managed and had an uneventful recovery. There was no erectile dysfunction and uroflow was normal. The patient was lost in the follow up, so long term outcome could not be studied. The treatment of penile strangulation is decompression of the constricted penis, so as to facilitate free blood flow and micturition, which requires resourcefulness and presence of mind.

KEY WORDS
Penile strangulation, Urethral injury, Catheterization. Suprapubic Cystostomy, Micturating Cysto-Uretherogram, Uroflowmetry


INTRODUCTION

Penile strangulation is a rare injury and most require only removal of the constriction and conservative management. Penile strangulating objects are usually rings, nuts, bottles, bushes, wedding rings etc. in an adult, while in children they tend to be rubber bands or hair coils. In adults these constricting penile bands, whether expandable or non-expandable, are placed deliberately by the person himself for masturbation or by the female counterpart to prolong erection.1 In children these are used to prevent enuresis and incontinence or as an innocent childish experiment. Because these bands occlude penile venous flow, most patients present to the emergency with penile edema. We report a case, which had hard plastic bottleneck as...
CASE REPORT

A 27 year old male presented in the emergency with markedly swollen penis. He had placed his penis in a hard plastic bottle for masturbation. The bottleneck got stuck and constricted the base of the penis.

On Examination there was a bottleneck around the base of penis. The distal penis and glans were swollen (Figure 1). Patient was not able to pass urine. There was no evidence of any skin ulceration. The distal penile sensations were normal.

The hospital carpenter was called to assist in cutting open that bottle. With the use of iron cutting saw (Hexa Blade) first the bottle was cut near the neck and then the bottle neck was cut open slowly and diagonally. The penis was held slightly bent downwards. Once one end of the bottle neck was cut open, the plaster spreader (used by orthopaedician) was use to hold the cut ends open and the whole bottle neck was cut opened and removed after 15 minutes of struggle.

There was ecchymosis of the skin. Patient was catheterized. Penile edema subsided completely in a week and patient had an uneventful recovery. There was no erectile dysfunction or decreased uroflow till one month of follow up. Long-term outcome could not be studied because patient did not come for further follow up.

DISCUSSION

Penile strangulation injuries range from simple penile engorgement to ulceration, necrosis, urinary fistula or even gangrene. As the patient is shy of telling this problem or patient is mentally abnormal they may present late and have severe injury. Metallic Rings cause less injury than nonmetallic rings.¹ As the corpus spongiosum and urethra are covered by a thin layer of fibrous tissue they are most susceptible to injury.

AL Bhat et al (1999) graded these injuries as follows.¹

Grade I Edema of distal penis. No evidence of skin ulceration or urethral injury
Grade II Injury to skin and constriction of corpus spongiosum but no evidence of urethral injury. Distal penile edema with decreased penile sensation.
Grade III Injury to skin and urethra but no urethral fistula. Loss of distal penile sensations.
Grade IV Complete division of Corpus spongiosum leading to urethral fistula and constriction of corpus cavernosa with loss of distal penile sensations.
Grade V Gangrene, necrosis, or complete amputation of distal penis

The present case had a grade I injury and required only the removal of constricting device. But more severe cases may require Supra Pubic Cystostomy (SPC), urethral reconstruction, degloving and Skin Grafting or some times amputation.

The evaluation of penile strangulation can be done by local temperature, sensation, color, ability to void, distal pulsations and local tissue injury at the site of constriction. In case of absent pulsations the distal blood flow can be checked by Doppler flow meter or wood lamp examination after IV Fluroscein.²

The choice of method for removal depends upon type, size, and time since strangulation and availability of the equipment. These methods may be aspiration of corpora, saws, grinders, and dental drills etc.³⁻⁵ After the removal of the object the urethra should be evaluated radiologically. If grade III-V injuries are found, SPC should done. In grade I and II injuries, simple emptying of the bladder by urethral catheterization may be required. Our case had only grade I injury and patient improved after removal of the constricting agent. Catheterization was done.

CONCLUSION

Penile strangulation is a serious injury requiring urgent
attention and intervention to prevent the complications. Aim should be restoration of blood supply and micturition with least discomfort to the patient. Long term follow up with Micturating Cysto-Urethrogram (MCU), Uroflowmetry etc. is necessary. These patients should also undergo a psychosexual assessment to prevent further episodes of such genital auto-mutilation.

REFERENCES

Distal ureteric atresia presenting as an abdominal lump in an adult

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ABSTRACT

A 26-year-old female, presented with discomfort and a lump in the left side of abdomen. Examination showed a non-tender cystic mass in the left lumbar region extending down to the pelvis, the lower limit being palpable through the left fornix. Investigations revealed a cystic mass extending from the left renal area to the pelvis and a non-visualized left kidney. Cystoscopy could not identify the left ureteric orifice. Surgical exploration showed a blind ending left ureter as a cystic mass, containing clear fluid capped by a hypoplastic left kidney. The mass extended from the left renal area to the pelvis. Left sided nephroureterectomy was performed.

KEY WORDS

Ureter, Atresia

INTRODUCTION

Ureteric atresia is a rare congenital abnormality. In distal atresia the ureter fails to communicate with the bladder and terminates close to it as a cul-de-sac. The proximal canalized ureter generally presents as a cystic mass. It may present in the infancy or childhood as an abdominal mass. But because of the relatively greater increase in the size of the abdominal cavity it is less apparent in adults and may remain unnoticed through out life. It may be incidentally discovered as a mass during investigations of persistent fever. One such case of distal ureteric atresia in an adult is reported because of its rarity.

CASE REPORT

A 26-year-old female, presented with vague discomfort in the left side of the abdomen for 18 months and a lump in the left side of the abdomen noticed for 8 months. Bowel and bladder habits, appetite, menstrual cycle were normal. On examination the patient was thin built, weighing 34kgs, afebrile and slightly pale. There was a non-tender, soft, cystic mass, measuring 5” x 6”, extending from the left costal margin down into the pelvis. It was fixed and had a well defined upper margin; the lower margin was not palpable. The mass showed no movement with respiration. The peristaltic sounds were normal. Per rectal examination revealed the lower limit of the cystic mass to lie

REFERENCES