

Penile Incarceration Caused by an Axe Ring: An Unusual Case of Sexual Perversion

The Editor,

Sir,

A 21-year old male presented to the emergency room with swelling of penile and scrotal areas for 24 hours. An axe ring had been placed over the penis for enhancement of sexual pleasure 24 hours previously. He said that he easily passed the penis through the axe ring when it was flaccid, but as the penis became erect, it was not possible for him to remove it. He did not report any difficulty passing urine.

On examination, there was marked local oedema of the penis (Figure). Attempts to remove it with lubrication, compression or cutting devices were unsuccessful. Under general anaesthesia and urethral catheterization, the ring was cut along two sides with the help of a steel angle grinder.



Figure: An axe ring constricting the oedematous penis.

To avoid burns from the sparks and excessive heating, the penis was isolated with pieces of tinfoil between the ring and the skin and cold normal saline was poured on the field. The ring was very thick and hard to cut. The patient could pass urine normally and on discharge after 48 hours with a normal penis. On follow-up, he never developed a stricture, or erectile dysfunction.

Penile strangulation is regarded as an emergent urologic disorder because immediate release is critical to prevent penile necrosis, urethral injury, erectile disorder and other unfavourable outcomes (1). The motivation for intentional placement of penile constriction devices is variable, depending on the patient's age. The adult population frequently reports erotic or autoerotic goals when intentionally placing constricting devices (2). Penile strangulation is a rarely described medical emergency, especially in the adolescent population (3).

The significant local complications include penile gangrene from prolonged vascular ischaemia which may require amputation as a life-saving measure, and the formation of urethra-cutaneous fistula. Systemic complications are less well documented in the literature. Renal impairment from the obstruction is one such complication (4).

The choice of method for removal depends upon type and size of the constricting device, time since strangulation and availability of the requisite equipment. These methods include aspiration of corpora, saws, grinders and dental drills (5). After the removal of the device, the urethra should be evaluated radiologically. If grade III–V injuries are found, suprapubic cystostomy should be done. In grade I and II injuries, simply emptying of the bladder by urethral catheterization may be required (5). The index case had only grade II injury and he made a full recovery after removal of the constricting agent.

Entrapment of metal rings that strangulate the shaft of the penis is a rare emergency. Removal of these may be challenging for the surgeon and may need resources not always immediately available. Early intervention and removal of the constricting device result in most patients making a full recovery with no need for further intervention.

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