

EAU GUIDELINES ON PENILE CURVATURE

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Introduction

Congenital penile curvature results from disproportionate development of the tunica albuginea of the corporal bodies and is not associated with urethral malformation. In the majority of the cases the curvature is ventral but can be lateral and rarely dorsal.

Diagnostic evaluation

Taking medical and sexual history are usually sufficient to establish the diagnosis of congenital penile curvature. Patients usually present after reaching puberty as the curvature becomes more apparent with erections, and severe curvature can make intercourse difficult or impossible. Physical examination during erection (autophotograph or after intracavernosal injection of vasoactive drugs) is useful to document curvature and exclude other pathologies.

Disease management

The treatment of this disorder is surgical correction deferred until after puberty. Surgical treatments for congenital penile curvature generally share the same principles as in Peyronie's disease (presented in detail in the next section). Nesbit procedure with excision of an ellipse of the tunica albuginea is the gold standard of treatment but many other techniques have

been described and employed. Plication techniques are widely used including techniques producing a de-rotation of the corporal bodies. Most of the time, dissection and mobilisation of the penile dorsal neurovascular bundle is required in order to avoid loss of sensation and ischemia to the glans penis.

Peyronie's disease

An insult (repetitive microvascular injury or trauma) to the tunica albuginea is the most widely accepted hypothesis on the aetiology of the disease. A prolonged inflammatory response will result in the remodelling of connective tissue into a fibrotic plaque. Penile plaque formation can result in curvature which, if severe, may prevent vaginal intromission.

The most commonly associated comorbidities and risk factors are diabetes, hypertension, lipid abnormalities, ischaemic cardiopathy, erectile dysfunction (ED), smoking, and excessive consumption of alcohol.

Two phases of the disease can be distinguished. The first is the acute inflammatory phase, which may be associated with pain in the flaccid state or painful erections and a palpable nodule or plaque in the tunica of the penis; typically a penile curvature begins to develop. The second is the fibrotic phase with the formation of hard palpable plaques that can be calcified, which also results in disease stabilisation.

Diagnostic evaluation

The aim of the initial evaluation is to provide information on the presenting symptoms and their duration (erectile pain, palpable nodules, curvature, length, rigidity, and girth) and erectile function status. It is mandatory to obtain information on the distress provoked by the symptoms and the potential risk factors for erectile dysfunction and Peyronie's disease.

Major attention should be given to whether the disease is still active, as this will influence medical treatment or the timing of surgery. Patients who are still likely to have an active disease are those with short symptom duration, pain during erection, or a recent change in penile curvature.

The examination should start with a routine genitourinary assessment, which is then extended to the hands and feet for detecting possible Dupuytren's contracture or Ledderhose scarring of the plantar fascia. Penile examination consists generally of a palpable node or plaque. Measurement of length during erection is important because it may have impact on treatment decisions.

Erectile dysfunction is common in patients with Peyronie's disease (> 50%) but it is important to define whether it pre- or post-dates the onset of Peyronie's disease.

Recommendations for the evaluation of Peyronie's disease	LE	GR
In the medical and sexual history in patients with Peyronie's disease, include duration of the disease, penile pain, change of penile deformity, difficulty in vaginal intromission due to deformity, and erectile dysfunction.	2b	B
In the physical examination, include assessment of palpable plaques, penile length, extent of curvature (self-photograph, vacuum-assisted erection test or pharmacological-induced erection) and any other possibly related diseases (Dupuytren's contracture, Ledderhose disease).	2a	B
Do not use PDQ in everyday clinical practice.	2a	B
Do not use ultrasound measurement of plaque size in everyday clinical practice.	3	C

Use Doppler US only in the case of diagnostic evaluation of ED, to ascertain vascular parameters associated with erectile dysfunction.	2a	B
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PDQ = Peyronie's disease-specific questionnaire; US = ultrasound.

Disease management

Non-operative treatment

Clostridium collagenase is the only drug approved for the treatment of Peyronie's disease by the FDA. No single drug has been approved by the European Medicines Agency (EMA) for the treatment of Peyronie's disease at this time.

Table 1: Non-operative treatments for Peyronie's disease

Oral treatments
Vitamin E
Potassium para-aminobenzoate (Potaba)
Tamoxifen
Colchicine
Acetyl esters of carnitine
Pentoxifylline
Phosphodiesterase type 5 inhibitors (PDE5i)
Intralesional treatments
Steroids
Verapamil
Clostridium collagenase
Interferon
Topical treatments
Verapamil
Iontophoresis
Extracorporeal shock wave treatment (ESWT)
Traction devices
Vacuum devices

Recommendations for non-operative treatment of Peyronie's disease	LE	GR
Use conservative treatment in patients not fit for surgery or when surgery is not acceptable to the patient.	3	C
Do not use extracorporeal shock-wave treatment to improve penile curvature and plaque size.	1b	C
Use penile traction devices and vacuum devices to reduce penile deformity and increase penile length.	2b	C
Do not use intralesional treatment with steroids to reduce penile curvature, plaque size or pain.	1b	B
Do not use oral treatment with vitamin E and tamoxifen for significant reduction in penile curvature or plaque size.	2b	B
Do not offer other oral treatments (acetyl esters of carnitine, pentoxifylline, colchicine).	3	C

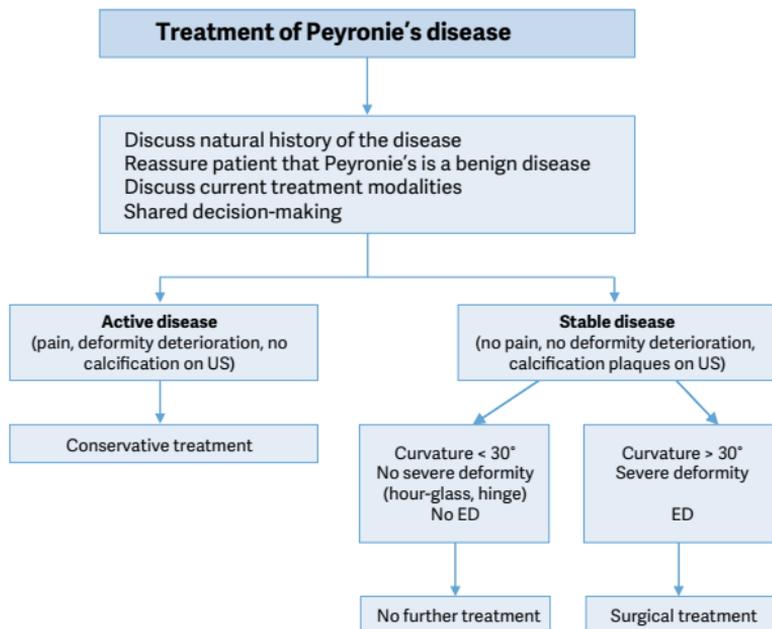
Surgical treatment

Recommendations for the surgical treatment of penile curvature	LE	GR
Perform surgery only when Peyronie's disease has been stable for at least 3 months (without pain or deformity deterioration), which is usually the case after 12 months from the onset of symptoms, and intercourse is compromised due to deformity.	3	C
Prior to surgery, assess penile length, curvature severity, erectile function (including response to pharmacotherapy in case of erectile dysfunction) and patient expectations.	3	C
Use tunical shortening procedures, especially plication techniques as the first treatment option for congenital penile curvature and for Peyronie's disease with adequate penile length, curvature < 60° and absence of special deformities (hour-glass, hinge).	2b	B
Use grafting techniques for patients with Peyronie's disease and normal erectile function, with no adequate penile length, curvature > 60° and presence of special deformities (hour-glass, hinge).	2b	B
Use penile prosthesis implantation, with or without any additional procedure (modelling, plication or grafting), in Peyronie's disease patients with erectile dysfunction not responding to pharmacotherapy.	2b	B

Table 2: Types of grafts used in Peyronie's disease surgery

Autologous grafts
Dermis
Vein grafts
Tunica albuginea
Tunica vaginalis
Temporalis fascia
Buccal mucosa
Allografts
Cadaveric pericardium
Cadaveric fascia lata
Cadaveric dura matter
Cadaveric dermis
Xenografts
Porcine small intestinal submucosa
Bovine pericardium
Porcine dermis
Synthetic grafts
Gore-Tex
Dacron

Figure 1: Treatment algorithm for Peyronie's disease



This short booklet text is based on the more comprehensive EAU Guidelines (978-90-79754-98-4), available to all members of the European Association of Urology at their website, <http://www.uroweb.org>.