PATIENT'S DETAILS

Mr.Babu ,64 years old male from Aminjikarai, Auto driver by occupation belonging to lower middle socioeconomic class

CHIEF COMPLAINTS

- Ulcer in the penis for **2 months**

HISTORY OF PRESENTING ILLNESS

- Patient was apparently normal 2 months back after which he developed **ulcer** over the penis
- Insidious onset, initially small in size , gradually progressed to attain the present size
- Not associated with pain
- Not able to **retract skin over the penis**

contd.....

- H/o discharge for the past one week- Serousanguineous discharge which is foul smelling
- No h/o trauma
- No h/o fever
- No h/o difficulty in passing urine
- No h/o pain while passing urine
- No h/o loss of weight /appetite

contd.....

- No h/o abdominal distension/jaundice
- No h/o bone pain
- No h/o cough with hemoptysis
- No h/o swelling in the inguinal region or elsewhere in the body

PAST HISTORY

- No h/o similar complaints in the past
- No h/o multiple sexual partners
- No h/o circumcision done
- No h/o Diabetes mellitus , hypertension , asthma, tuberculosis, epilepsy , jaundice, sexually transmitted diseases, cardiovascular diseases
- H/o hospitalization for hernia surgery on right side 30 years back in GRH

PERSONAL HISTORY

- Consumes non veg diet
- Normal bowel and habits
- Not a smoker
- Consumes alcohol 180ml-3 times a week
- No h/o drug abuse
- No h/o tobacco/betel nut chewing

FAMILY HISTORY

- No relevant family history

ALLERGY HISTORY

- No h/o allergy to any drug or food

GENERAL EXAMINATION

- Patient is conscious, oriented moderately built and nourished
- No pallor, icterus, cyanosis, clubbing, pedal edema, generalised lymphadenopathy

VITALS

- Pulse rate-76/min,regular in rhythm normal volume and character, no vessel wall thickening,no radioradial / radiofemoral delay, felt in all palpable peripheral vessels
- Respiratory rate-16/min
- Blood pressure-110/80 mmHg measured in right upper arm in sitting posture
- Temperature-afebrile

LOCAL EXAMINATION

- After getting consent and explaining the procedure to the patient ,with a male attender by the side the patient was exposed from midchest to midthigh and was examined in bright light

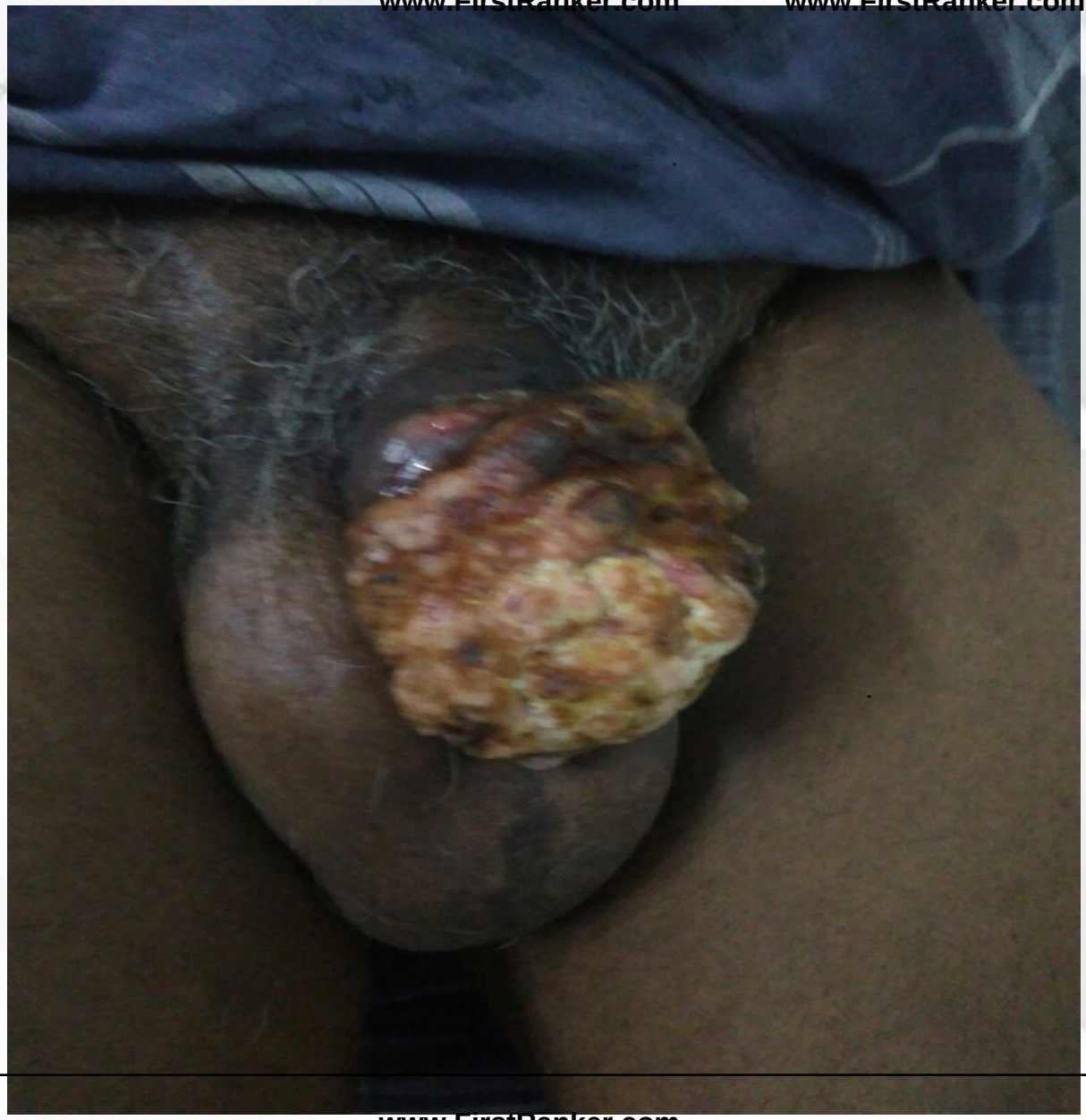
INSPECTION

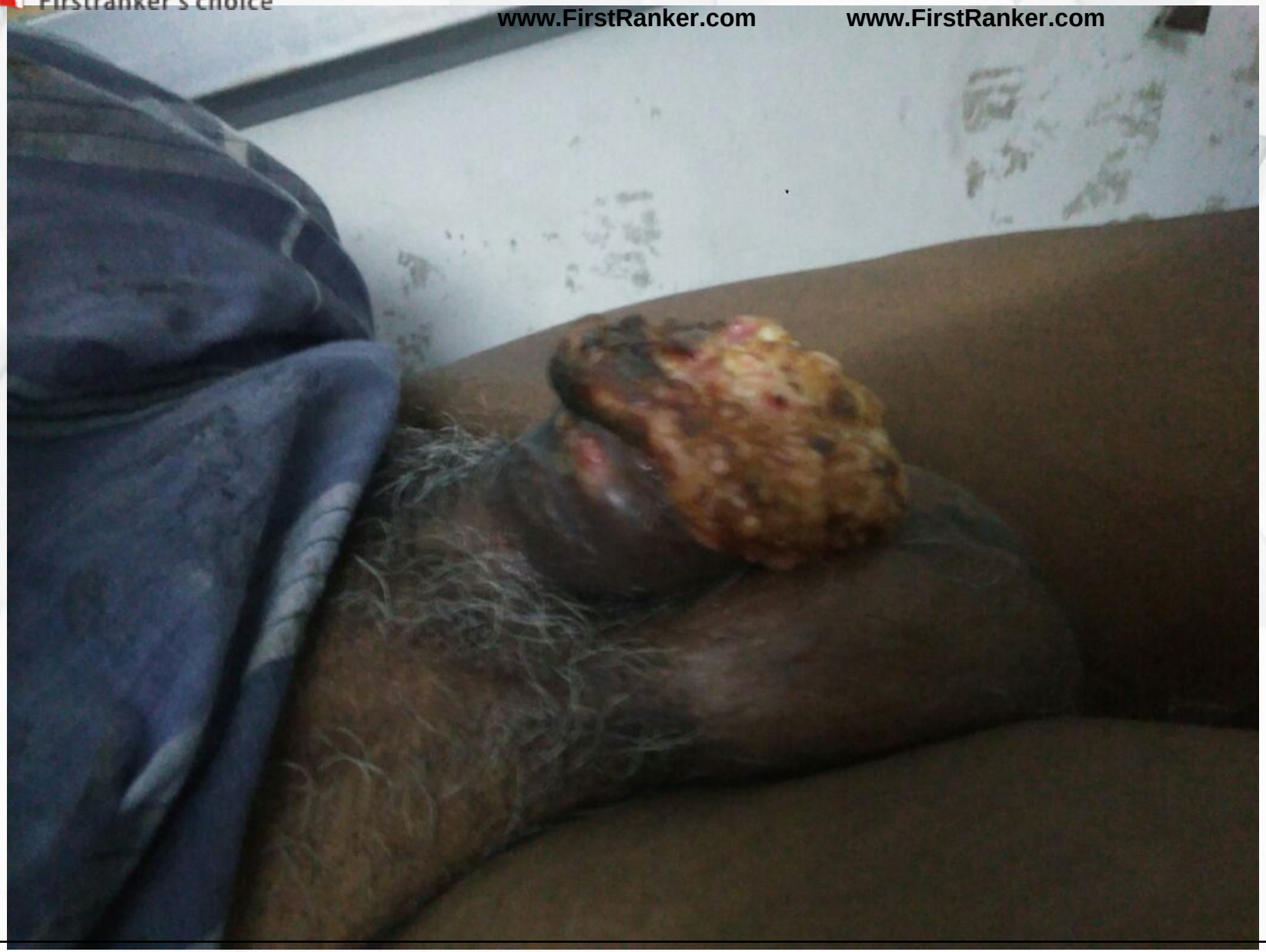
- A irregular ulcer of size **5x5cm** seen on the dorsum of the shaft of penis
- **Margin**-ill defined
- **Edges**-everted and rolled out
- **Floor**-necrotic tissue
- **Extent**-from 4cm from the shaft of penis to the glans
- **Serosanguineous discharge** present

- A small oval ulcer of size 1x1cm seen above the lesion 3 cm from the shaft of the penis
- Margins are well defined
- Floor- **pale pink** in colour
- Surrounding skin edematous
- No pigmentation , scars, sinuses seen
- Inguinal region: a linear scar of size 6cm present in the right inguinal region which is healthy

PALPATION

- Warmth (+)
- Tenderness (+) present over the lesion and the skin surrounding the skin
- Inspectory findings of site, size, shape, extent are confirmed on palpation
- Bleed on touch
- Base is indurated
- Glans , prepuce, urethral meatus - not able to find





PALPATION OF INGUINAL LYMPH NODES

- Multiple,bilateral, hard, mobile lymph nodes in the inguinal region
- Largest node – 2x2cm present in the right inguinal region with well defined margins 5cm from the pubic symphysis and 7cm from the anterior superior iliac spine
- Not warm ,not tender
- Node is discrete and mobile, hard in consistency
- Skin over the node-normal and pinchable

- From the level of umblicus to the inguinal region-no other lesions found

OTHER SYSTEM EXAMINATION

- RS- normal vesicular breath sounds heard no added sounds
- CVS- S1,S2 heard no murmurs
- CNS-no focal neurological deficit
- Abdomen- soft,non-tender,no organomegaly, no palpable mass ,no free fluid, hernial orifices are free
- Spine and cranium-normal

DIAGNOSIS

- Carcinoma penis involving shaft of penis with bilateral palpable lymph nodes (Stage III – Jackson’s staging)

MANAGEMENT

- Investigations

BASELINE

1)Blood- total count , differential count, ESR, bleeding time , clotting time,Hb%

2)Blood – sugar

3)Urine-sugar,urea,albumin

4)Chest X-ray

5)ECG

6)Renal function test

7)Serology – HIV , HBsAg, VDRL

SPECIFIC

1)Edge wedge biopsy

2)Punch biopsy of proliferative growth

3)USG Abdomen

4)FNAC of lymph node

5)CT abdomen

6) Sentinel node biopsy of cabana

TREATMENT

- Total penectomy with perineal urethrostomy
- Lymph nodes-antibiotics for 4 to 6 weeks -resolves then observe
- Lymph nodes palpable after antibiotics- bilateral ilioinguinal node dissection