FRACTURE OF PENIS

Dear Editor,

I would like to share my experience of treating a rare case of fracture penis with injury to the erectile tissue without associated urethral injury. Mechanism of injury in this patient being self inflicted [1] in order to relieve prolonged erection. Fracture penis is actually a misnomer, as the organ lacks bony support. [2] the tunica albuginea is thinned out to 0.5 mm in an erect organ, and thus more prone to injury. [3]. Forcible bending of the erect organ most commonly during aggressive sexual activity, ruptures this membrane by a sudden 'pop' or a snap or a crackling sound that has led this to be termed a fracture.[4].

Present case was a 21 yrs old unmarried serving soldier who reported to hospital with severe pain, swelling and deformity of penis. He gave history of forcible downward bending of the erect organ. Immediately it was followed by a snap associated with severe pain, swelling and flaccidity of penis. Patient reported 24 hrs after the injury and passed urine after injury. Local examination revealed swollen, demuniscient, deformed penis, tender to touch and deviated to the left side. It was managed by exploration and evacuation of subcutaneous haematoma, repair of rent in tunica albuginea and corpus cavernosum with 30 prolene interrupted sutures. Postoperative period was uneventful, managed with antibiotics and analgesics.

Reviewed after one month, he had optimal erection with no residual deformity.

Some authors advocate conservative management[5]. But the prolonged hospitalization and a higher rate of complications have prompted the universal acceptance of an early and prompt surgical intervention.

REFERENCES

1. Redman JF, Meidema EB. Traumatic rupture of the corpus cavernosum: a case report. *Jour Uro* 1981; 129:830-831.
2. Zenteno S. Fracture of the penis: a case report. *Plastic Reconst Surg* 1973; 52: 669.
3. Texture John H. Management of penile trauma. In: Nyhus LM, Baker RJ, eds. *Mastery of Surgery Series [Urologic Surgery]*. Little Brown & Co., Boston, 1992: 490.
4. Abulata KA, Awad RA. Fracture shaft of penis; non surgical treatment in three cases. *J Roy Coll Surg Edin* 1983; 266-268.
5. Pyrer JP, Hin JJ, Packham DA, Yates Bell AJ. Penile injuries in particular reference to injury to the erectile tissue. *Brit J Urol* 1981; 53: 42-46

Lt Col S CHAWLA

Classified Specialist (Surgery), 172 MH C/o 56 APO

EMOTIONAL FACTORS IN ALOPECIA AREATA

Dear Editor,

Numerous anecdotal reports and some systematic studies indicate that emotional factors play an important precipitating role in some cases of alopecia areata (AA), while in other cases emotional changes arise secondary to cosmetic disfigurement and may then perpetuate AA [1-3]. Many of these studies had important methodological shortcomings like use of nonstandardised subjective measures for the assessment of anxiety and depression, lack of control groups or control groups that were inadequately defined. In view of the shortcoming of the earlier studies and the paucity of Indian reports, the present work was undertaken.

Twenty five consecutive outpatients with confirmed diagnosis of AA at Command Hospital (Northern Command) during the period April 97 to November 97 formed the patient group. The three control groups consisted of age and sex matched normal healthy subjects, outpatients with fungal skin disease and outpatients with neurosis. All subjects underwent psychiatric examination (diagnosis as per ICD-10) and following standardised psychological tests: Sinhas Anxiety scale (SAS) [4] and Hamilton depression rating scale (HDRS) [5]. Statistical analysis were done using the chi square test and Kruskal-Wallis one way analysis of variance by ranks.

There were no statistically significant differences among the four groups of subjects in socio demographic characteristics (Table 1). Four AA patients were suffering from Adjustment disorder with depressed mood, two from dysthymia while two were alcohol dependent. Analysis of the scores of the four groups on the SAS (KW=25.5; df=3; P) and the HDRS (KW=59.96; df=3; P) shows significant differences between the groups. In order to determine the significance of the difference between means taken in part, the critical difference was calculated which was 21.65. Results are

shown in Table 2.

The main finding of the present study was that patients with AA had significantly higher levels of anxiety and depression as compared to normal controls and also patients with fungal skin infections. Since the AA patients were symptomatic at the time of evaluation it is probable that the anxiety and depression in AA patients was secondary to their dermatological condition. similar findings were reported by Moffart [6]. In agreement with the above, it was found that depressive symptoms preceded the onset of AA in only one of the six patients having depressive disorders.

Presently AA is treated by a combination of local and systemic drugs. Apart from reassurance not much effort is made to alleviate the emotional distress of these patients suffering from this chronic and visible disfiguring condition. Stress inducing life events, including loss and reactive depression are commonly accepted as causative or precipitating factors for AA. It is obvious that amelioration of anxiety and depression by appropriate drug therapy will not only alleviate their psychological distress but may have an indirect beneficial effect on the dermatosis itself. Some authors remain confident of the effectiveness of psychoanalytic psychotherapy. but their reports have serious shortcoming: the duration of follow-up is inadequately standardised, and both the possible impact of other therapeutic variables eg. changes in life circumstances, and the high rate of spontaneous remission of AA are disregarded [6].

We conclude that AA patients have higher levels of anxiety and depression as compared to normal subjects and patients with fungal skin infection. The identification and treatment of emotional disturbances in AA patients will not only improve the subjective well-being of these patients but may even mitigate the exacerbations of the disorder. The role of liaison psychiatry in the management of AA