ECRONICON OPEN ACCESS

EC EMERGENCY MEDICINE AND CRITICAL CARE
Case Report

When a Sexual Intercourse Goes Bad

Jabour Soukayna*, El Aitari Khadija, Boujida Nadia, El Fenni Jamal and Saouab Rachida

Department of Radiology, University of Mohammed V of Rabat, Morocco

***Corresponding Author:** Jabour Soukayna, Department of Radiology, University of Mohammed V of Rabat, Morocco.

Received: August 08, 2025; **Published:** October 15, 2025

Abstract

Penile fracture is a rare but urgent urological emergency, typically resulting from blunt trauma to an erect penis during sexual intercourse. It involves a rupture of the tunica albuginea surrounding the corpora cavernosa and may, in some cases, extend to the urethra. Most commonly affecting sexually active men between the ages of 20 and 40, the condition often arises from forceful impact against the partner's perineum during misdirected thrusting. Diagnosis is primarily clinical, based on patient history and characteristic signs such as sudden pain, swelling, and penile deformity-commonly referred to as the "eggplant deformity". Imaging modalities, particularly ultrasound, along with retrograde urethrography, MRI, or urethrocystoscopy, can assist in confirming the diagnosis and evaluating the extent of injury. Prompt surgical repair remains the treatment of choice and has been associated with favorable outcomes in terms of sexual and urinary function. This report presents the case of a 35-year-old man with a unilateral fracture of the right corpus cavernosum, confirmed by ultrasound, who underwent successful surgical management with an uneventful recovery. The case underscores the importance of early recognition and intervention in minimizing long-term complications.

Keywords: *Penile Fracture; Trauma; Ultrasonography*

Introduction

Penile fracture is an uncommon but serious urological emergency, typically caused by blunt trauma to an erect penis, most often during sexual activity. It involves a tear in the tunica albuginea of the corpus cavernosum, which becomes thinner and more fragile during erection. Although diagnosis is primarily clinical, imaging-particularly ultrasonography-is valuable for confirming the extent of injury. Retrograde urethrography is used when urethral damage is suspected, and MRI may be helpful in complex cases. This report presents a case of penile fracture in a 25-year-old man, highlighting the importance of prompt radiological evaluation and surgical management.

Case Report

We report the case of a 35-year-old male, previously healthy, who presented to our emergency department 34 hours after sustaining a penile injury during sexual intercourse. The incident occurred when a misaligned thrust caused his erect penis to strike his partner's perineum. He immediately felt a sharp pain, heard a distinct "pop," experienced rapid detumescence, and developed progressive penile and scrotal swelling. Despite the trauma, he reported no hematuria and maintained normal urination.

On examination, the penis was deviated to the left with marked swelling, particularly at the proximal shaft. A purplish discoloration and significant hematoma were noted, giving the typical "eggplant deformity" (Figure 1). The rolling sign was positive, and localized tenderness was elicited on the right shaft. The rest of the physical exam and systemic review were unremarkable.

Figure 1: *Appearance of eggplant penis following a misstep of coitus during sexual intercourse.*

Ultrasound imaging revealed a tear in the tunica albuginea of the right corpus cavernosum, with a hematoma measuring 1.5 cm. The corpus spongiosum and testicles appeared intact.

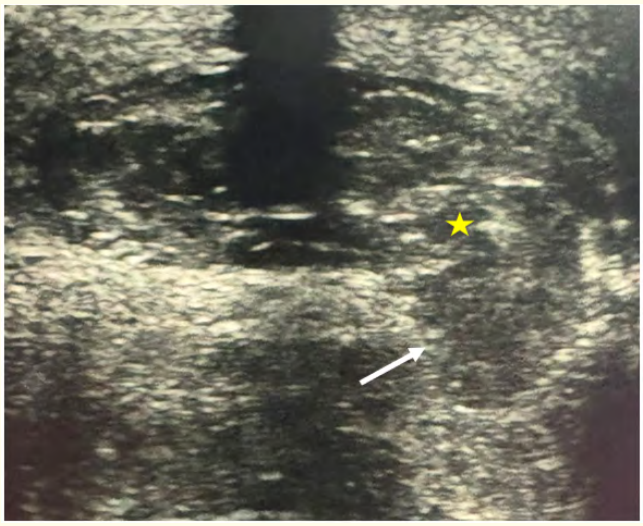

Figure 2: *Tunica albuginea defect (star) with significant infiltration and hematoma (white arrow).*

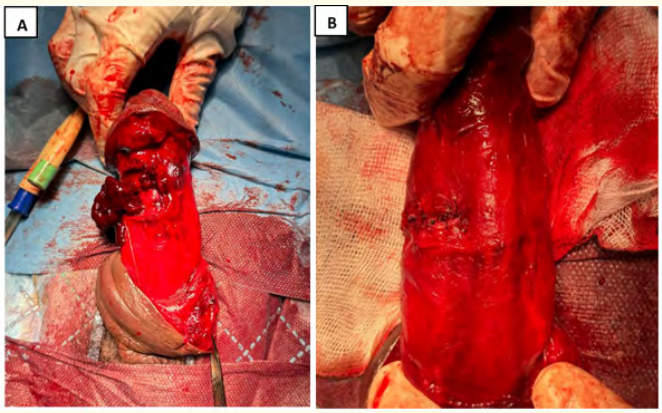

Figure 3: *A) Line of fracture of the tunica albuginea of the right cavernous body after evacuation of the hematoma. B) The edges of the fracture line sutured by using separate stitches.*

The patient underwent prompt surgical intervention under spinal anesthesia. A targeted incision over the palpable mass allowed hematoma evacuation and identification of a 15 mm horizontal tear on the right dorsal tunica albuginea. The defect was repaired using interrupted Vicryl 3-0 sutures. A urethral catheter was placed intraoperatively and removed on postoperative day three.

Postoperative recovery was uneventful. The patient was discharged on a 7-day course of oral antibiotics. At six-month follow-up, he reported normal voiding and erectile function, with no signs of fibrosis, curvature, or palpable abnormalities.

Discussion

The diagnosis of penile fracture is primarily clinical, based on a thorough physical examination and patient history. A typical presentation includes a cracking or snapping sound, followed by acute pain. Rapid onset of penile swelling and deformity is usually observed, often with deviation opposite to the side of the tear. A hematoma of varying size typically forms, giving the penis its classic "eggplant deformity" [1,2].

In certain cases, a palpable clot may be felt at the fracture site, known as the "rolling sign" [3,4]. It is essential to assess for associated injuries, particularly urethral damage, which occurs in approximately 10 - 33% of cases. Signs such as macroscopic or microscopic urethrorrhagia, painful urination, or urinary retention may suggest urethral involvement [5]. Injury to the dorsal penile artery or deep dorsal vein may also be present and is sometimes indicated by a "butterfly-shaped" perineal hematoma [4].

Once the diagnosis is clinically suspected, urgent surgical intervention is warranted. In scenarios where the diagnosis is uncertain, imaging may help guide management and identify concurrent injuries. Among the differential diagnoses, one must consider a "false penile fracture", which mimics the clinical presentation but lacks the characteristic snapping sound or sudden detumescence. It typically involves a rupture of the superficial dorsal vein, which does not require surgery [4].

Another differential is a "closed fracture" of the corpus cavernosum. This occurs during sexual activity, often includes an audible crack, but lacks external hematoma or visible swelling. The external appearance of the penis remains largely unchanged, though it shares the same long-term complications, such as fibrosis and erectile dysfunction. Imaging is advised in such cases [6].

There is currently no clear consensus regarding the role of imaging in penile fracture. However, recent literature suggests that when doubt exists, MRI should be the first-line imaging modality, as it provides the highest diagnostic accuracy, although its availability can be limited. Ultrasound is a more accessible, second-line alternative, though it is operator-dependent [4,7].

Timely referral to a surgeon is critical, as surgical delay increases the risk of complications. Although early intervention is ideal, surgery remains beneficial even in delayed presentations, albeit with higher intraoperative and postoperative risks. If left untreated, the patient may develop fibrotic scarring, erectile dysfunction, penile curvature, or urethrocavernous fistulas [5]. Surgical management involves: Evacuation of the hematoma, hemostasis, suturing of the tunica albuginea, and Inspection of the contralateral corpus cavernosum. Intraoperative urethroscopy (fibroscopy) is recommended at the slightest suspicion of urethral injury.

Conclusion

The incidence of penile fracture, or rupture of the corpora cavernosa, appears to be underreported in sub-Saharan Africa. Over a period of seven years, we documented five cases, highlighting its rarity but also the likelihood of underestimation. This condition constitutes a urological emergency, requiring prompt recognition and intervention. While the causes are diverse, in our limited series, the most frequent etiology was coital misalignment.

Although the diagnosis is primarily clinical, imaging may be beneficial in ambiguous or equivocal presentations. Due to the risk of spontaneous complications-including fibrosis, erectile dysfunction, and penile deformity-timely therapeutic intervention is critical.

Management approaches include both surgical and conservative (medical) options, all aiming to achieve penile rest and recovery. However, current evidence strongly supports the predominance of surgical treatment, especially in its role in preventing long-term sequelae and ensuring favorable functional outcomes.

Bibliography

1. Z Kozacıoglu., *et al*. "An update of penile fractures: long-term significance of the number of hours elapsed till surgical repair on long-term outcomes". *Turkish Journal of Urology* 43.1 (2017): 25-29.
2. AM El-Taher HA., *et al*. "Management of penile fracture". *Journal of Trauma: Injury, Infection, and Critical Care* 56.5 (2004): 1138-1140.
3. Bertolotto M and Pozzi Mucelli R. "Non penetrating penile traumas: sonographic and Doppler features". *American Journal of Roentgenology* 183.4 (2004): 1085-1089.
4. Barolia DK., *et al*. "Isolated corpus spongiosum and urethral injury during sexual intercourse: a rare case". *International Journal of Innovative Research in Medical Science* 2.1 (2016): 64-66.
5. Natchagandé G., *et al*. "Fracture de verge à la Clinique universitaire d'urologie de Cotonou". *Médecine d'Afrique Noire* 60.6009 (2013): 368-372.
6. Kpatcha TM., *et al*. "Notre expérience de la prise en charge de la fracture de verge au CHU de Lomé". *African Journal of Urology* 23.4 (2017): 342-246.
7. Barry MII., *et al*. "Fracture de verge: analyse rétrospective de 22 cas au service d'urologie de l'hôpital Ignace Deen, CHU de Conakry Guinée". *Uro-Andro* 1.6 (2016): 273-278.

Volume 9 Issue 1 January 2025