Penile Horn—A Case Report

*Ashok Kumar** *V. N. S. Yadav*** *R. N. Sharma**** *(Mrs.) P. K. Agarwal*****

Review ef Literature :

The commonest site for cutaneous horns is the scalp. They are excessive overgrowths of cornified epithelium. Horns on penis are rare and they have been extensively reviewed by A. A. Hasan et al. in 1967. First case of penile horn was reported in 1854 and on reviewing the literature it was found that 42 cases have been reported so far.

Case Report :

A 32 years old man was admitted to Gandhi Memorial and Associated Hospitals, Plastic Surgery Department, Lucknow on May 30. 1974 for the treatment of a horny projection on glans penis. Three years previously the patient had developed a painful nodule on the glans near the uretheral opening, which had been excised, but the raw surface never healed. He consulted a quack who applied some strong chemical over it. Following that the part began to dry and turn back. It became progressive in size and gradually started encroaching on the glans. There was no past history suggestive of syphilis. gonorrhoea, tuberculosis or diabetes. There was a history of pain but no history of bleeding urinary disturbances or uretheral discharge.

On examination there was a hard, indurated, dirty greyish mass extending from the upper margin of prepuce and covering the glans (Fig. 1 a & b). It was painless. A sulcus existed between the mass and the glans penis. Regional lymph nodes were not palpable.

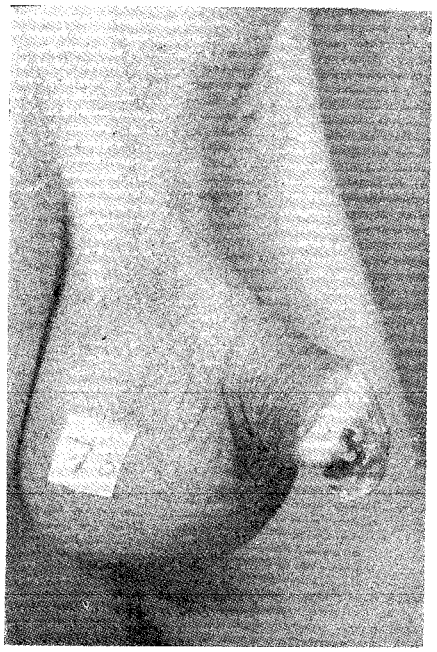
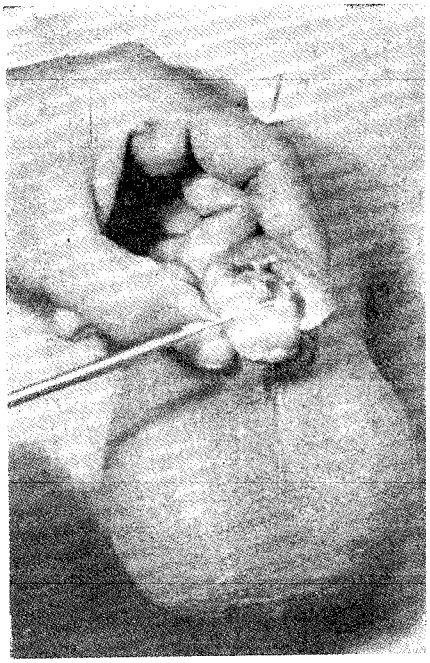


Fig. 1—Pre.operative photograph showing the lesion (a) Right lateral view

*Resident, Department of Surgery, K.G. Medical College, Lucknow.
**Registrar, Deptt. of Plastic Surgery, K.G. Medical College, Lucknow.
***Professor and Head of the Department, Postgraduate Department of Plastic Surgery, K. G. Medical College, Lucknow.
****Reader in Postgraduate Deptt. of Pathology, K.G. Medical College, Lucknow.

The lesion was excised widely including healthy tissue at its base. The skin defect was made good my mobilising the local skin. The wound healed with primary intention. When examined an year later there was no recurrence.

The specimen on naked eye examination appeared irregular, hard, dirty greyish in colour and measured 1.7 by 2.6 cm. Surface was rough and hyperpigmented. Histopatho-



(c) Showing the meatal opening

logical examination revealed papillary acanthosis surmounted by marked keratinisation. The subepithelial zone was infiltrated by small round cells, There was no infiltration by plasma cells and also there was no evidence of necrosis (Fig. 2). Histological picture was compatible with the clinical diagnosis of a penile horn. There was no evidence of malignancy.

Discussion :

In most of these cases, true etiology is uncertain but the probable factors are congenital phimosis and viral infection. In our

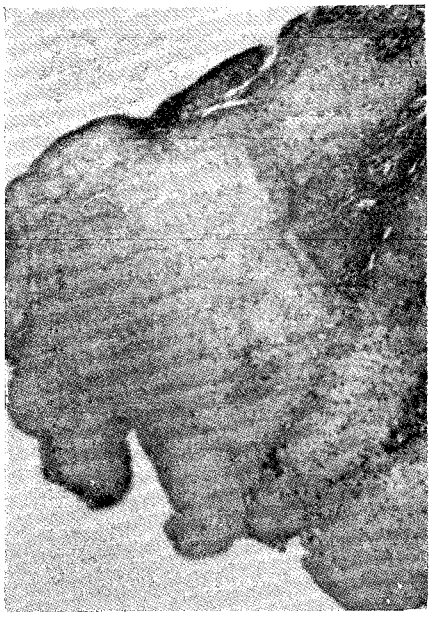


Fig. 2—Microphotograph showing papilliferous proliferation of squamous epithelium

case no phimosis was seen. These horns are likely to develop malignant ulcerations at their base and the treatment of choice is wide excision. If malignant change has occurred partial amputation of the penis is required. In most of the reported cases the initial symptoms were pain and tenderness which were also present in our case.

Summary :

A case of penile horn, a rare entity has been reported. It was treated by wide local excision.

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