Peyronie’s disease

Treatment should always restore sexual function

Even though he was not the first to describe it the name of Francois Gigot de la Peyronie,1 surgeon to Louis XV of France, has become synonymous with the enigmatic condition of Peyronie’s disease. The disease is characterised by irregular dense plaques of fibrous tissue, usually on the dorsum of the penile shaft, accompanied by distortion or angulation of the erect penis and in the early stages pain on erection. The erectile deformity may interfere with vaginal penetration making coitus difficult or impossible. If the plaque is extensive and associated with fibrosis of the underlying cavernosal erectile tissue it may result in a band like constriction or wasting of the penile shaft, which leads to flaccidity of the corpora distally. Failure of erection in men with Peyronie’s disease is usually psychogenic and secondary to pain or performance anxiety. Impotence, however, may be caused by coexistent penile arterial insufficiency, autonomic neuropathy (particularly in diabetic men), or cavernosal venoocclusive incompetence.2

The aetiology of Peyronie’s disease remains obscure, and it is not possible to predict its natural course in an individual patient at presentation. Although the pain almost always subsides within a few months, the plaque, and hence the degree of erectile deformity, may either resolve, stay the same, or progress further. The uncertainty about the outcome as well as the need for a period of observation must be explained to the patient.

Peyronie’s disease can now be evaluated much more objectively using modern technology. The dimensions of the plaque, the presence of calcification within it, and fibrotic encroachment upon the cavernosal spongy tissue can be accurately defined by means of high resolution ultrasonography.14 Penile arterial inflow can be simultaneously measured using a duplex scanner which combines the above imaging modality with a pulsed Doppler system.15 Morphological alterations in the cavernosal bodies can be determined also by computed tomography,6 nuclear magnetic resonance imaging of the erect penis,7 and by cavernosography.4 Dynamic infusion cavernosometry8 may usefully complement cavernosography if venous leak impotence is suspected. The erectile deformity may be recorded by polaroid photography either at home9 or in the outpatient clinic by inducing an erection with an intracavernosal injection of papaverine.10

The variability in the course of the disease makes it difficult to evaluate the treatments used in the initial acute phase. Thus vitamin E,10 potassium aminobenzoate,12 and ergotamine1415 are of doubtful benefit, and there is no convincing evidence that radiotherapy,16 ultrasonic treatment,17 or steroids injected directly into the plaque1819 influence the disease apart from perhaps hastening the resolution of pain. The therapeutic potential of purified clostridial collagenase injected into the plaque is presently undergoing experimental and clinical trials in the United States.20 As yet the preparation is neither available nor licensed in Britain.

The usefulness of surgery in Peyronie’s disease is well defined. If the patient is unable to penetrate because of curvature of the penis then it may be straightened. In Nesbit’s operation single or multiple ellipses or diamond shaped segments of normal tunica albuginea are excised from the corpora cavernosa opposite the point of maximum curvature; suturing then straightens the penis, albeit at the expense of length.2122 This operation is simpler, less time consuming, and more predictable than attempts at excising the plaques and replacing the defects with a dermal graft or other substitutes.23 If the patient has organic impotence then a semirigid penile prosthesis may be inserted with or without excision or incision of the plaques.24 Alternatively, intracavernosal self injections of papaverine may be employed, if necessary, as an adjunct to corrective surgery. In patients with psychogenic impotence self injection may be required only short term. In conclusion, there is no reason why Peyronie’s disease should end the sexual function of any man.

We must hope that the efforts to carry out well designed epidemiological studies after the accident will be successful. A heavy responsibility lies with authorities and scientists, particularly in the Soviet Union, to make use of the opportunity created by the tragic events at Chernobyl to expand our knowledge on health risks associated with exposure to ionising radiation.

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Empty theatres

Looking at part of the problem provides only part of the answer

Last year the National Audit Office took a long hard look at the use of operating theatres in five district health authorities and concluded that they were busy for only a little over half of the available time, with cancelled sessions and overruns accounting for most of the disuse. The report claimed that much tighter administration, unconstrained by historical allocations of theatre time to individual specialties and consultants, was needed for improvement to occur. These observations, which most clinicians would accept as an account of reality however much they might divorce themselves from the remedies then proposed, were lost in the more general crises that affected NHS funding and resources in the ensuing months.

The Committee of Public Accounts has now given its approval to the audit office’s opinion on the need for change. It endorses the view that underuse is mostly due to three items: “traditional practices and habits, framed for the convenience of consultants and staff”; scheduled and unscheduled absence of medical staff; and the absence of— and consultant resistance to—the provision of locum cover. In regard to the last the committee makes one statement that is hard for those at the sharp end to accept and does not give the public much cause for comfort when it says (para 34) that, in keeping operating theatres running, “it is unacceptable that the quality of locums should be a factor.”

Surgeons might be forgiven a sense of déjà vu. No one likes the long waiting lists, almost exclusively surgical, that have characterised the NHS since its inception. But both the original report and the comments of the Public Accounts Committee make the mistake of looking at the use of theatres in isolation. This has led them to underestimate the difficulty of arranging the smooth progress of a routine surgical patient through a system plagued by bottle necks of many kinds and by recurrent crises of funding. (In the case of my own hospital these financial crises reduced the provision of beds for months on end and led to a doubling of the waiting time for routine surgery.)

The vexatious matters of having enough beds and flexibility of theatre allocation to deal with an inevitably and almost randomly fluctuating case load were described in detail in the BMJ recently by surgeons from the Whittington Hospital. These observers also spelt out the fact that increasing the use of operating theatres will also increase costs— anathema to most managers in 1988. This conclusion will not please politicians making capital from the report.

Throwing at the problem requests for tighter administration and for more disciplinary action against a minority of poorly performing consultants is unlikely to result in radical improvements. Norms for theatre performance need to be established not in isolation but against the background of the overall function of hospital services. We might then see that rather than having what seem to be underused theatres we need more provision to deal with fluctuating and essentially unpredictable demands in an unstable health delivery system. Certainly the accounts committee is being too certain of its remedies on the basis of facts that form only part of a complex issue. Some would argue that this approach is characteristic of political comment about the problems of the NHS.

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