



Localized Penile Cancer Glans (Squamous Cell Carcinoma of Glans Penis Case Report)

Mohammed Abdul Qader Al-Malmi, MD¹, Tawfeq Hassan Albadani²

¹Assistant Professor of Dermatology and Venereology, Al-Kuwait University Hospital, Sana'a University Medical School, Sana'a, Republic of Yemen.

²Professor of Urology, Sana'a Republic of Yemen, Yemen.

Abstract

Background: Penile cancer is uncommon. Penile squamous cell carcinoma is the most common penile malignancy, behaves similarly to squamous cell carcinoma in other parts of the skin.

Objective: The objective of the study was to study ulcerative eroded skin disease in the glans penis.

Patients and Methods: Forty years old farmer Yemeni male patient presented with erosive ulcerative painful skin lesion in all his glans penis. The duration was one year. Skin biopsy was done.

Results: The clinical picture and the investigations showed the patient had localized penile cancer or squamous cell carcinomas. No specific laboratory studies or tumor markers are diagnostic for penile cancer. The patient was treated by partial panectomy. There were no regional lymph node enlargements.

Conclusion: localized penile cancer was rare in republic of Yemen. This case was first reported.

CASE STUDY

Forty years old Yemeni male patient presented with ulcerative eroded skin lesion localized to his glans penis. Figure (1). Skin biopsy showed keratinization, epithelial pearl formation, and various degrees of mitotic activity. The normal rete pegs are disrupted, and invasive lesions penetrate the basement membrane and surrounding structures. Figures (2,3,4). The patient treated by partial penectomy.



Figure 1. localized erosive ulcerative skin lesion in the glans penis

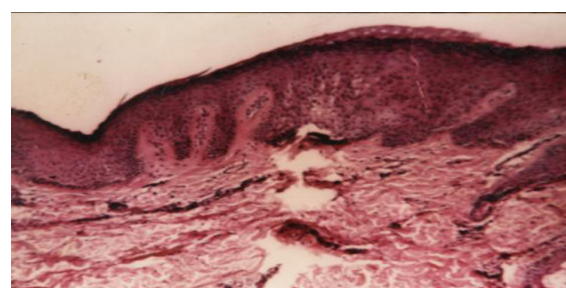


Figure 2. keratinization, epithelial pearl formation, and various degrees of mitotic activity. The normal rete pegs are disrupted, and invasive lesions penetrate the basement membrane and surrounding structures.

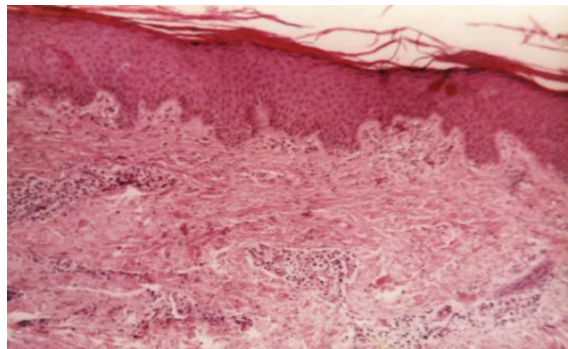


Figure 3. keratinization, epithelial pearl formation, and various degrees of mitotic activity. The normal rete pegs are disrupted, and invasive lesions penetrate the basement membrane and surrounding structures.

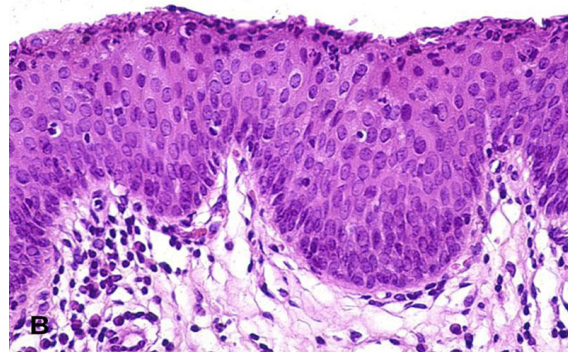


Figure 4. keratinization, epithelial pearl formation, and various degrees of mitotic activity. The normal rete pegs are disrupted, and invasive lesions penetrate the basement membrane and surrounding structures.

COMMENT

Patients with carcinoma of the penis tend to delay seeking medical attention, with 15-50% delaying medical attention for more than 1 year from onset. This delay is attributed to embarrassment, guilt, fear, ignorance, and personal neglect. Patients often try to treat themselves with various skin creams and lotions. These may appear to be effective for a time, which further delays the diagnosis and worsens the prognosis. Delays may also be attributable to the physician. Some patients with penile cancer report that they receive various salves and antibiotics from their primary care physicians before they see a urologist. A delay in diagnosis and therapy not only affects the likelihood of survival but also limits the ability to retain a functioning and cosmetically satisfactory result. Nearly 25% of dysplastic or neoplastic penile lesions are misdiagnosed as being benign. A biopsy should be considered in any uncircumcised male who presents with a penile lesion.

The Jackson classification is as follows:

Stage I (A): The tumor is confined to the glans, prepuce, or both.

Stage II (B): The tumor extends onto the shaft of the penis.

Stage III (C): The tumor has inguinal metastasis that is operable.

Stage IV (D): The tumor involves adjacent structures and is associated with inoperable inguinal metastasis or distant metastasis.

The TNM classification of the primary tumor (T) is below. Note that the following description is devoid of N (node) and M (metastasis) descriptions. These stages simply relate the presence or absence of nodal and distant metastases.

TX: Primary tumor cannot be assessed.

T0: Primary tumor is not evident.

Tis: CIS is present.

Ta: Noninvasive verrucous carcinoma is present.

T1: Tumor invades subepithelial connective tissue.

T2: Tumor invades corpora spongiosum or cavernosum.

T3: Tumor invades the urethra or prostate.

T4: Tumor invades other adjacent structures.

The WHO histopathological classification is as follows:

Grade 1 - Well differentiated, with 33% undifferentiated cells

Grade 2 - Moderately differentiated, with 33%-66% undifferentiated cells

Grade 3 - Poorly differentiated, with more than 66% undifferentiated cells

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