Inflammation and infection

Penile Mondor’s disease- an understated entity

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A R T I C L E   I N F O

Keywords:
PMD
Dorsal vein thrombosis
Penile Mondor’s disease

A B S T R A C T

We present a case of Penile Mondor’s Disease (PMD) in a 36-year old male patient. PMD is an under-recognised and uncommon condition which presents with pain on erection and cord-like thickening of the dorsum of the penis. The diagnosis of PMD is usually confirmed with ultrasound imaging. The course of PMD is self-limiting, with multiple adjunct treatments proposed to hasten the recovery process however the evidence to support these treatments is limited.

It is important both Primary Care Providers and Urologists are aware of this condition in order to provide appropriate information to patients regarding treatment options and prognosis.

Introduction

Thrombosis of the superficial veins of the thoracoepigastric region was first described in the late 1930’s by French Physician, Henri Mondor. Thrombosis of the superficial dorsal vein of the penis was first reported by Braun-Falco in 1955, although, in the context of generalised phlebitis. It wasn’t until 1958 that the first case of isolated superficial dorsal vein phlebitis of the penis was reported by Helm and Hodge 1-3, with this entity prescribed the term ‘Mondor’s Disease’. Minimal studies have assessed the incidence of Mondor’s disease. A study of 1296 patients by Kumar et al.1 is the largest known series. This assessed a cohort of patients attending a sexually transmitted disease (STD) clinic with incidence noted at 1.39%.

The pathophysiology of PMD remains unclear, however multiple precipitants have been proposed including trauma, STD clinic with incidence noted at 1.39%. The patient had no significant medical history. Diagnosing Mondor’s Disease is not straightforward with multiple differential diagnoses including Peyronie’s Disease and Peyronie’s Disease. Sclerosing lymphangitis is characterized by thickened and dilated lymphatic vessels with serpiginous morphology. Peyronie’s disease is caused by fibrosis of the tunica albuginea and results in abnormal curvature of the penis. Sclerosing lymphangitis is easily differentiated from PMD with colour doppler ultrasound. Dorsal vein thrombosis and the subsequent lack of colour doppler flow is not demonstrated in sclerosing lymphangitis 4.

PMD is usually conservatively managed and considered a benign pathology with no long-term sequelae. The optimal management is contentious, with various management regimes proposed. Proposed regimes include the use of antiplatelet therapy, anticoagulation therapy, topical heparin treatment, abstinence from sexual activity and as a salvage option, thrombectomy.1,3 The duration of symptoms reported in the literature ranges from 1 to 24 weeks.3

Case presentation

A 36-year-old male was referred by his Primary Care Provider with a 2-week history of painful erections and a focal thickening on the dorsolateral aspect of his penis. No pain was noted while his penis was flaccid.

The patient denied genital trauma, vigorous sexual behaviour or other triggering events. The onset of discomfort was progressive. He denied concerns of a similar nature previously. No dysuria, urinary frequency, urethral discharge, haematuria or haematospermia was noted. The patient had no significant medical history.

The man noted having had a maternal great uncle with polycythaemia rubra vera, however both his haemoglobin and haematocrit were within normal ranges.

On examination, external genitalia appeared normal. Testicles were normal to palpation however inspection of the penis revealed a palpable thickening with associated tenderness on the left dorsolateral aspect of the penis. Prominent left inguinal nodes were palpable.

The patient proceeded to have a full STD screen along with urine microscopy which both returned negative.

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https://doi.org/10.1016/j.eucr.2020.101176
Received 29 February 2020; Accepted 10 March 2020
Available online 2 April 2020
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The patient then proceeded to focused genital ultrasound which confirmed a focal thrombosis of the superficial dorsal vein of the penis.

“The penis was examined and there is thrombus involving the superficial dorsal vein which extends over a length of 4–5cm. The vein is non-compressible and has no vascularity. This is consistent with Monodor’s disease” (see Figs. 1 and 2).

Multiple discussions were had with both Urology and Haematology services with the patient then commenced on twice daily heparinoid cream (0.3mg/g) to be applied locally to the area of discomfort.

The man was advised to abstain from sexual activity until resolution of symptoms but reassured that this should have no long-term sequelae on sexual function.

The gentleman was followed up with weekly phone reviews and a clinical review at 4 weeks.

At 6 weeks, the patient’s pain and induration was clinically resolved.

At 8 weeks, the patient’s pain remained resolved and his erectile function was normal.
Discussion

PMD remains an uncommon presentation however its incidence is believed to be understated.

PMD presents in a typical manner however the duration of these symptoms remains variable. The patient should be reassured that PMD follows a benign course and should have no long-term sequelae.

Options for treatment typically follow a conservative approach with the mainstays being anti-inflammatory use and sexual abstinence. There is no strong consensus in the literature for using anti-coagulation (oral or topical) however in this instance, when the patient was presented with multiple options he desired to add topical heparin cream as it was felt there was minimal side effects at stake. As stated in previous literature, this patient’s PMD followed a benign course and no longer has any symptoms or dysfunction.

Conclusion

PMD is a benign, self-limiting condition that presents in a classical manner.

It is important that both Primary Healthcare Providers and Urologists are aware of PMD, the common features and the reassuring counselling that should accompany its diagnosis.

The combination of history, examination and imaging should lead to a confident diagnosis of PMD.

Consent

Verbal consent was obtained from the patient involved in this case for specific details of his case to be documented and published.

Declaration of competing interest

There are no conflicts of interest to declare.

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