Complete Diphallus

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Case Report

A 2-day-old male child male child was born to a 28 year old primigravida mother, at term (39 weeks and 4 days of gestation), by normal vaginal delivery. The parents were married nonconsanguineously. There was no family history of any congenital malformations and no history of abortions in the mother. The mother conceived spontaneously and also had an uneventful antenatal and immediate perinatal period. She received iron and folic acid supplementation during the pregnancy with no history of any known teratogen exposure during pregnancy. The baby cried immediately after birth and required only routine care. He weighed 2.8 kg and had normal vital parameters. On neonatal examination, he was found to have two completely separated phallus and completely separated scrotum with each scrotal sac containing palpable testis (Image 1). Examination of the other systems was essentially normal. The baby was kept nil per oral, started on intravenous dextrose and was referred to higher center. The baby was passing urine through both the urethra and he was planned for further evaluation including MRI (Magnetic resonance imaging) of the urogenital tract followed by surgery for complete diphallus with bifid scrotum.

Diphallia, i.e. duplication of penis or clitoris, is an extremely rare congenital anomaly with an incidence of about 1 in 5 million live births [1]. The first case was reported in 1609 with less than 100 cases been reported worldwide so far and no two cases have been identical [2]. Initially, diphallia was classified into 3 main types: (1) diphallia of the glans alone, (2) bifid diphallia, and (3) complete diphallia [3]. Later, Abdel reclassified diphallia into: True diphallia (complete and partial) and bifid phallus (complete and partial) [4]. For true diphallia, there has to be presence of corpora cavernosa and corpus spongiosum in both phalluses [5]. Therefore, our case was a case of true complete diphallus. The latest classification divides diphallia into four groups based on embryological, anatomical, clinical, and therapeutic implications; these are (a) true diphallia, (b) hemiphallus, (c) pseudodiphallia, and (d) partial duplication [6].

Surgical correction of diphallia varies depending on the defect and may be performed in one or multiple stages and as no two cases are same it needs to be individualized with the aims of achieving
proper urinary continence, urinary stream, and erection with adequate cosmesis [8].

**Authorship and contributor Ship**

Both the authors have contributed in management of the patient, literature search and writing the manuscript and both approve the final manuscript.

**References**